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PUBLISHED BY AUTHORITY OF THE  
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\*Dr. Whitehead is serving as editor of THE QUARTERLY following Dr. Bigelow's appointment as Commissioner of Mental Hygiene.

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The Psychiatric Quarterly, formerly the State Hospital Quarterly, is the official organ of the New York State Department of Mental Hygiene.

Volumes begin with the January number. Individual subscription rate, \$6.00 a year in U. S. and its possessions; \$6.50 elsewhere.

Editorial communications, books for review and exchange should be addressed to the editor, Utica State Hospital, Utica 2, N. Y.

Business communications, remittances and subscriptions should be addressed to the State Hospitals Press, Utica 2, N. Y.

Entered as second-class matter April 17, 1917, at the postoffice at Utica, N. Y., under the Act of March 3, 1897.





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Contributions from any reliable source will be considered for publication. Manuscripts should be addressed to The Editor, PSYCHIATRIC QUARTERLY, Utica State Hospital, Utica 2, N. Y.

Manuscripts should be submitted in original (not carbon) copy, typewritten cleanly, double-spaced, with wide margins, typed on one side of the paper only. Paper should be light weight, bond finish, and opaque; onion skin should not be used. The author should keep a copy for convenience in editorial correspondence.

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Received	Editor	Research
DATE		
Dated	12. 8. 70	
Vol. No.	9	130



## SOME PRINCIPLES OF BRIEF PSYCHOTHERAPY

BY WALTER BONIME, M. D.

In attempting to formulate principles of brief psychotherapy of the neuroses, it is important to recognize the problem essentially as one of recapitulating principles of *sound* psychotherapy. There is nothing basically new or special about this form of treatment. Its uniqueness resides in its disadvantages. Brevity in psychotherapy is a limitation. Rigidity is an ingredient of all neurotic problems and resistance always a factor impeding resolution. These elements cannot be overcome by strong, swift impact. As a matter of fact, these elements account to a large extent for the usual protractedness of effective work in this field. With limitations in time, the effectiveness of treatment will also be curtailed. In other words, brief psychotherapy is not streamlined; it is restricted psychotherapy. The problem of the brief psychotherapist is that of working according to the soundest psychotherapeutic principles in order to accomplish the greatest possible good under restricted conditions.

As in any psychotherapy of the neuroses, one of the chief goals is that of equipping the individual to deal independently with his life problems subsequent to treatment. One seeks more than the mere alleviation of acute distress. Achievement of such an objective always involves the development by the patient of some degree of insight into his personality structure. This may mean only a single aspect or several, and the depth of the insight may also vary. Revealing statements by the psychiatrist may often prove helpful. Usually, however, little more than an intellectual grasp can be attained by this means, plus some basis for guidance through the immediate distress. Life situations alone are often enlightening to the patient. There are, however, no technical shortcuts to true insight. Personalities are not integrated rapidly. If there is but a brief period in which to work, it is necessary to utilize it for the fullest possible resolution of the most crippling personality factor within reach.

Some principles can be formulated as a guide for achieving the greatest possible result while working under the handicaps of limited contact. This paper represents an attempt at such formulation and presents, as well, a case of traumatic war neurosis in which such principles were followed and in which psychotherapy



over a brief period brought fruitful results. The principles apply basically to any neurosis in any psychotherapeutic setting.

### *Case*

This is a case of traumatic war neurosis in a 37-year-old chief steward (H. S.). He was treated during World War II at a merchant marine rehabilitation center. In May 1942, over two years before the writer first saw him, he underwent the chief traumatic experience associated with his manifest war neurosis. It occurred during the daytime in the Caribbean area. He was in the cold storage compartment of the ship when a torpedo struck the engine room, separated from him by a steel plate bulkhead or wall. The closed door was jammed by the buckling of the plates. The lights went out and the plates bulged and tore apart at the seam, shooting out the rivets like machine gun bullets, some of them hitting him painfully across the back. Jars of mayonnaise and pickles fell and covered the floor with a slippery mass of broken glass. Steam hissed from pipes, ammonia escaped from the freezing system, explosive fumes pervaded the space, and the propeller shaft, no longer turning against the resistance of the water, roared and vibrated at top speed.

One man knew, by chance, that the steward had gone below just before the torpedo hit. He ran down and pried open the door with a metal bar, releasing the steward in the midst of his terrified and frantic efforts to get out. The two men rushed to the deck and plunged, in life preservers, over the side of the rapidly sinking ship. They got to a raft which was still attached by rope. One man started, just as the ship was plunging, to cut the rope to keep the raft from being sucked under. The steward, not yet on the raft, grasped its slats and hung on, vaguely thinking that, if the rope were partially cut, it would snap from the tremendous dragging tension and that he would be carried back to the surface by the greater buoyancy of the raft, while, alone, he might sink deeper in the suction of the ship. He clung, while being dragged under some distance, and then the raft broke free from the ship and carried him and two or three others to the surface, where they climbed aboard.

There were 15 or 20 men in the water within a short distance of the raft, some only a few feet away. The steward had shipped with some of them for three years. Sharks swarmed among them.



There was no way of reaching these men. One after another, they were dragged under. Familiar faces, arms, voices, striving toward the raft with agony and fear, suddenly disappeared while the steward watched. He struck at the sharks with a boat hook to draw blood and distract them from the men—but to no avail. Those on the raft could do nothing to help their shipmates in the water. The steward saw eight go down. Of a crew of 65, only 20 survived, some having got off in lifeboats. These 20 drifted in the boats for 29 days, before rescue.

After returning to this country the steward began to have nightmares. These nightmares were always recapitulations of the torpedoing, in part or completely, with emphasis on the three outstanding aspects: (1) being trapped in the storeroom; (2) being sucked under; (3) being helpless on the raft while watching shipmates dragged under by sharks.

He was tense, often tremulous, could not stand confinement, ate poorly. At first he could get to sleep by taking a couple of shots of whisky, later he required more, still later he drank constantly, vainly seeking some kind of relaxation and rest. (He had never before had an alcoholic problem.) The process of repatriation took four months, and he returned to New York in mid-September. The following year was consumed by a long struggle for rehabilitation. It involved three separate admissions to a rest center, totaling six months, with shore duty in between, while maintaining contact with the rest center doctor. The year was also a stormy alcoholic one, but with some general improvement.

He finally shipped out against the advice of the doctor who had been carrying him nearly a year. He returned after a brief one and one-half month voyage, "feeling lousy."

He stayed ashore a month without drinking and shipped again for a three-month trip. This trip involved his being in the harbor of Bari, Italy, the night that port sustained a devastating bombing raid. Many ships were blown up and the next morning found the harbor littered with wreckage; protruding sunken ships; and floating bodies, many of them those of merchant seamen. This experience disturbed him deeply and brought back the old nightmares. He slept hardly at all, and often stayed up all night talking to different men in order to avoid the sleep that brought recurrence of the nightmares. He returned in March and shipped out three days later "because I wanted to see if I couldn't get rid of this thing myself."



This trip took him eventually to Normandy where his ship lay off the beach on D-Day and during the next three days and nights. There he saw landing barges blown up, bodies in the water. There were artillery fire, air attacks, floating mines. Even before this, however, the gunnery practice preparatory to D-Day had distressed him and revived the old nightmares. After D-Day, the events of the torpedoing began to come back during the day through various stimuli. He had begun to have dizzy spells and shaking spells. While on an England-to-France shuttle run after D-Day he developed such a bad shaking spell upon starting down a ladder that he fell to the deck below and woke up with a fractured skull in a Normandy hospital. After hospital ship and army hospitals, he was finally repatriated through the War Shipping Administration and eventually arrived at the rest center for convalescence.

This steward was first interviewed by the writer at the rest center nearly two and one-half years following the experience which had precipitated his traumatic war neurosis. He described it when asked to, without any histrionics, yet as though relating an experience of the past week. It was quite vivid to him since he was still reliving it in his nightmares. He was worried, depressed, tired. He could not sleep, except to wake up shortly with all the anxiety associated with a nightmare. He had suffered from "pain in the head" (which he distinguished from ordinary headache) since the skull fracture about two months earlier. He had occasional dizzy spells and occasional nausea and vomiting. There were no frank neurological signs. He had not touched liquor in a year. At the end of this first interview, he was given some encouragement regarding prospects for getting over his symptoms.

A few days later he was seen again, and a good deal of his past life was discussed. The significant facts can be briefly summed up. He was the oldest of three boys of a family which, while not impoverished, had to struggle for moderate comfort. The mother worked, and the father was a professional soldier. After World War I, the father was in the national guard and was able to live at home much of the time, where he maintained strict discipline. The patient, in spite of the discipline, worshipped his father. It was a great event for the patient when, in his early 'teens, he was admitted to the guard to drill under his father. When he was 17, his father's death came as a great blow. The home, however, was kept



intact. Four years later the three boys found their family spirit disrupted by the remarriage of their mother. The stepfather had nothing in common with the boys; and, entering the home, he came between them and their mother. All that the patient earned, nevertheless, went into the home until three years later when he married a girl whom he had been seeing for about two years. He was then 24 years old. About a year later, early in the depression, he started going to sea. Two children were born during the first three years. The steward was able, nevertheless, to maintain a fairly comfortable apartment for his family. On returning from a voyage after four years of marriage he found the apartment empty of family and furniture. He traced his wife and children and found that his wife had set up housekeeping with his furniture and even his clothes, and was living with another man. After a futile attempt at reconstruction of the marriage, he completely renounced her and all other women. He pursued a lonely life, sending most of his money to his mother and rising to the highest rating in his occupation at sea, that of chief steward. At the end of seven barren years the torpedoing occurred.

After this general exposition of the significant events in his life, the conditions were set for analytic interpretation, for a direct attack upon the problem. He was told that there appeared to be a relationship between past events and the traumatic force of the torpedoing experience. It was suggested to the patient that the nightmares and all of the features of his illness since that war experience did *not* represent symptoms of an emotional, a psychiatric, sickness that started *during* the war and which seemed too severe to overcome. Rather, it looked as if certain aspects of his torpedoing experience were devastating to him because they represented in an intensified fashion what had been happening to him all his life. Everything of value to him had at various stages of his life been sucked under, dragged under and lost. His father had been dragged away from him by death. The home life that survived had been torn from him by his mother's remarriage. His own family and wife had, in turn, been as ruthlessly sucked under.

In all these situations he had had to sit by helplessly. He had felt as helpless at the side of his dying father as he had felt watching his shipmates dragged under by sharks. He was unable to save the home spirit when his mother remarried an uncongenial and calculating stranger. He was helpless to reconstitute his fam-



ily when his wife deserted him. In all these situations in which the virtual foundations of his existence were destroyed, the outstanding feelings were a sense of imminent annihilation and a profound sense of helplessness. He was himself trapped and dragged down; and he saw all that was precious to him being destroyed as he sat by, inadequate and unable to rescue anything.

It was pointed out that the torpedo experience was one that would have been difficult for almost anybody to endure. It was emphasized, however, that its effects did not represent a sickness acquired during the war but were due largely to the symbolic significance they had for difficulties he had struggled with all his life. He was told that the solution of his difficulties was a problem upon which *he and the doctor would collaborate*. Optimism was expressed over the fact that a clearer orientation had been formulated.

That night he had a dream; and, in it for the first time, his father appeared. Pressure of medical work imposed a delay of two days before the next therapeutic meeting. During this time he was preoccupied by the dream and the fact of his father's appearance in it. He was eager to discuss it with the doctor. When they finally met, the therapist apologized for the delay. Following is the dream that the patient related. (This and the subsequent dreams are reproduced as written down by the man.)

*Dream No. 1.* "I was on a ship, sitting at a desk in the fo'c'sle. I was alone. The ship was sinking. There had been no torpedoing or anything like that. The ship was just sinking. I sat there and sank with the ship—no fear or any such feeling. Finally the ship settled on the bottom and I got up, opened the door and walked out. I walked through a dark tunnel. Suddenly there was a door and I opened it and walked into a room. There I saw my father, sitting behind a desk with a big book in front of him. He looked up at me and said sort of sternly, 'You can't stay here. Go and make something of yourself; you can't stay here.' Suddenly I was in a lifeboat. I was alone and felt lost and depressed. I looked up and could see land—a city in the distance. There was a man in uniform standing on the beach waving for me to come over. I couldn't make out who he was, but he seemed familiar. I got up and walked out of the lifeboat and across the water to where the man had been on the shore. When I reached the shore he wasn't there. There were crowds of people, all strangers. I looked



around to find this man and wanted to find out from the people going by where he was. I was sure that if I could find him he'd lead me to a certain place in the city where I would stay and everything would be fine. I kept looking everywhere for him and then suddenly woke up. I was sweating all over. My heart was beating fast, and I was terribly scared."

He was asked if during the past year or two he had sometimes felt very depressed, felt like chucking the whole business. He replied, "Yes, that's just it. During the last two months especially I have been terribly depressed. I've often wished I'd gone down with the ship."

The following interpretation was given: "Going down with the ship is what you would like to have been able to do to solve your problem or, rather, get rid of it. Your life has become very threatening, full of fear of having anything of value sucked under, torpedoed, devoured by sharks. Sinking with the ship represents the same sort of thing you sought with alcohol. You meet your father who represents the dead whom you wish to join. He, however, says, 'You can't stay here, go and make something of your life.' This is your own recognition that death is no solution. It also represents a real feeling of yours, of wanting to get something out of life. Such a decision, however, leaves you again alone and literally at sea—as you were in the lifeboat. Having made a positive approach to your problems, however, your dream goes on and presents life to you again—the busy city, filled with people. Someone is encouraging you to join in life again. [Associations are of a previous doctor, also another WSA official who helped him get a job, and still an uncertainty of identity persisted. The face kept fading and coming into focus again in a new form, never quite recognizable. Possibilities suggested to him included the new doctor, social workers, and nurses.] Recognizing that to find a person who would lead you to a certain place where all would go well is an impossibility, represents a recognition of reality in your dream. No one can really lead you by the hand to a life without struggle or disappointment. The important thing in your dream is your turning toward life. The prospect, however, of venturing again *alone* is too much and you awake in great fear, the kind of fear associated with the other dreams where you are being annihilated, the fear that makes you turn away from life. It is as though annihilation, loss, helplessness, are the only prospects before you if you face



life. Your dream shows, however, a real sign of progress in you, for it is still *your* feeling in the dream, one of hope and of desire to face life and to take part in it."

That night he had another dream which puzzled him and which he was eager to discuss.

*Dream No. 2.* "You [doctor] and Dad are in a big office sitting together behind a very large desk. You are just as distinct and clear in features and dress as if I were to talk to you now, person to person. Dad's features were clear, but I can't seem to remember how he was dressed. I seemed to have some job, or something that I was ordered to do, and I did not think that I was doing it properly. Dad did not talk to me directly, did not even say hello when I came in the office, but you and he seemed to confer together and you explained to me that you yourself and whoever I worked for or had to do something for were more than satisfied with the way I was conducting this business. I seemed to feel that I had failed to do properly in every detail whatever I was supposed to do and that I had failed somewhere and that I wanted to go somewhere that I would be all alone. I seemed to be disgusted with myself and ashamed because whatever I was supposed to do seemed so simple. You talked to me directly, Doctor, and explained to me that you and (others?) were entirely satisfied with the way I was conducting this job. You explained to me that as far as I had gone I had done well and that to let someone else in the mission or job would fail and that you and (others?) depended on me to finish whatever it was I was supposed to be doing. You put your arm across my shoulder and walked to the door with me as I left the office. I walked down a long, long corridor and it seemed that I was not pinned, or held down, or that a great weight or some very great trouble had been taken away from me. It is hard to express but in some way I felt free. I woke up and I was sitting up in bed, and that is how I felt when I came to myself and that is exactly how I have felt since I arose this morning and at the present time. I feel better way deep inside today than I have in the past ten years. The way I feel is hard to explain only that I feel at ease and that there are people who give a damn and that I do what a man is supposed to do."

He was willing this time to attempt to interpret by himself and offered the following: "I know you're helping me and I go in to see



you. But no matter how you help me or what I do, there's something holding me back."

The following additional interpretation was offered him: "That something is a lack of confidence in self, it's a feeling of having no value as a human being, of not counting for anything. Both your father and I represent people who feel you are a decent and capable individual and can carry your own weight in life. Your feeling of not letting anyone in to help you on the job indicates your further acceptance of reality as it came out in the previous dream where the fellow on the shore who called you back to life disappeared when you reached the shore, signifying that you can get something out of life only by carrying your own weight and can't expect to have others make the way easy. This time you are not frightened by the prospect as you were in the earlier dream. The prospect of a self-confident life of your own frees you of the burden of fears, the burden of helplessness."

That night there was a dance. In reporting it he said, "I sat and watched the other fellows having a good time. I felt why shouldn't I have these things, too? I got up and danced and joked and really enjoyed myself."

A night later he had another dream.

*Dream No. 3.* "I do not remember if the ship had been hit by a torpedo, do not even see a ship in this dream. I am on a raft; there are other men with me but they don't seem to mean anything to me and it doesn't seem to mean anything to me if they are there or not. I am standing on the raft and what it is in my hand I can't make clear, but I am killing sharks left and right and it doesn't seem that I am doing this because of what they are or what they have done. It seems to be that there is some pent-up hatred inside of me that I am venting on them. They seem to be a hindrance to me and are in my way of a figure who is beckoning to me from shore, who seems to be pleased with what I am doing to try to get to him. When my way is clear and I am almost to this officer, I woke up. My heart was pounding and I was soaking wet with perspiration. But I felt good and did not seem to have a [discouraged?] feeling that I had in preceding dreams."

It was suggested that the dream represented his fury at those influences which had always resulted in his loss of the good things in life. His striking out at the sharks represented a real self-assertion, a determination to get past the obstacles and get posi-



tive satisfactions, seek a real life of his own. Out of this discussion developed, not a repetition of the major misfortunes already recounted, but a series of situations in which he was submissive, self-effacing, exploited without complaints or revolt on his part. He said, "I've always sat back and let people walk all over me. I always felt it was better to keep things peaceful." He told of how it used to mean so much to him as a child to visit his aunt in the country and how it was always his brother who was sent by the parents to spend summer vacations there while he would work, sometimes being a milkman's helper at one dollar a week. Even then he couldn't play ball with the boys on Sundays.

He described how he had sat at the bedside as his father died. "Five minutes before father died he pulled me to him and said, 'For God's sake, be good. Do the best you can.'" Then the patient added, "I've tried to be nice ever since. It seems I've done myself harm through it. The nicer I am to anybody, I expect him to be the same and goddam if I don't get a kick in the back." It was indicated to him that "being nice" often represented a failure to stand up for his rights. His generosity, good will and fairness were not overlooked, and emphasis was placed in this context on his failure to assert himself. He spoke of the good time he had had at the dance and concluded the interview with: "After talking with you this week, I'm not going to be stepped on any more, I know it."

The succeeding night he dreamed again. As with the other dreams he followed the request to write it out. The following was submitted:

*Dream No. 4.* "This dream last night started with my being on a ship. I do not remember getting on or where. I am on this ship and we are under way at sea. I am sitting at my desk in my quarters at my books. I close the book I am writing in, leave my quarters, walk out on deck, and jump overboard. I have absolutely no sensation of sinking or any feeling of going under, everything just turned black. How soon after this I woke up I do not know, but when I did I remember this very clearly and I could not sleep for the rest of the night."

A brief interpretation was offered. It was suggested that the contemplation of a complete change of personality all at once, or even the effort to initiate self-assertion, had become overwhelming.



He had reverted to the former method of solution, running away. He replied, "I knew the dream meant an easy way out."

The next night there was another dance, he had a turn with every girl there, and thoroughly enjoyed himself. He was discharged soon afterward and received a two-month temporary release from maritime service. In spite of financial and other practical difficulties, he kept a positive view of things, and finally obtained a job as instructor in cooking at a maritime school.

In the course of the routine physical examination for this appointment, however, the chest x-ray revealed an entirely unsuspected minimal pulmonary tuberculosis which disqualified him for that or any other satisfactory position in his profession. He obtained part-time work in a seamen's home on the waterfront and struggled for five months with barely enough money for food and lodging. Frequently during this long period of struggling the nightmares returned. During the last few weeks his discouragement made him no longer able to refuse the constant invitation to drink. He was seen by the writer a few times shortly after discharge, was helped in practical arrangements and by encouragement. At the end of five months he was seen again and an x-ray was ordered which showed sufficient pulmonary pathology to have him hospitalized. It is felt that there had been a good chance of a favorable outcome for this man if tuberculosis had not prevented him from capitalizing on the positive forces which had clearly been mobilized in him when he was discharged from the rest center. The case is presented because of the richness of the clinical material, because it illustrates definite forward movement during short-term therapy, and because the clinical experience embodies the therapeutic principles herein discussed.

#### DISCUSSION

One important principle of brief psychotherapy illustrated in the handling of the foregoing, is that of making a careful evaluation of long-established personality trends as opposed to focusing upon precipitating circumstances (Principle 5, in the following). This is regarded by the writer as crucial in dealing with the war neuroses in general. The tendency in handling war neuroses has been that of relating immediate reaction too much to the war situations themselves. The situational factors of war are intense and dramatic, and tend to preoccupy the therapist as well as the patient.



The author's experience with merchant seamen suffering from war neuroses has impressed upon him that the war neuroses are not circumscribed in time or form. Rather, even with traumatic war neuroses, the situational factors engendered by war serve essentially as precipitating factors, operating in the same way as other traumata under civilian circumstances. Their dynamic effects develop in terms of previously existing personality disturbances. Anyone undergoing the series of traumatic experiences of this steward would certainly be unstabilized. It was necessary, nevertheless, to evaluate his reactions to these experiences in terms of long-established personality difficulties over a broad range of experience in order to attain a substantial therapeutic result. As an isolated set of experiences these traumatic episodes of war appeared to the steward to have disabled him permanently, as irrevocably as though he had lost a limb. The war traumata were placed, however, in their proper perspective as involving problems that had existed long before. They became part of something that had always been disturbing. They represented the sort of thing this man had been wanting to overcome all his life. They involved problems for which he could, perhaps for the first time, have hope of successful solution.

#### FORMULATION OF PRINCIPLES

Following is offered a formulation of some principles of brief psychotherapy. The term "brief psychotherapy" implies a contrast with long-term psychotherapy. The formulation given here is stated largely in terms of this implied comparison.

Unity of basic principles is emphasized as underlying the two types of therapy. Brief and long-term methods equally involve these principles, which represent the fundamental demands of *any sound* psychotherapy. Divergences arise from the special demands of psychotherapeutic situations in which brevity of contact is a prominent factor. Such divergences are not the basis of new or exclusive psychotherapeutic principles. The factor of brief contact, however, justifies a restatement of general psychotherapeutic principles with modifications where they are demanded by the special situation. The psychiatrist practising brief psychotherapy must:

1. *Take a much more active role* than in long-term therapy. Greater activity is particularly needed in interpretation. This is



so even though this factor runs counter to the growth of insight on a deeper plane. Deeper insight accompanies the *prolonged* struggle by the patient in long-term therapy for understanding of himself. There is, however, not enough time in brief psychotherapy for the patient to develop the necessary sense of responsibility, the skill, confidence, and desire, which are prerequisites to his working out his difficulties on a plane of deep insight. Greater activity on the part of the doctor also applies in other spheres. The therapist must give more of himself in terms of friendliness, moral support, encouragement. His active assistance in practical arrangements and his direct advice are often needed. These elements are recommended in brief psychotherapy somewhat in the spirit of pointing out a necessary evil. This evil consists of their fostering dependence and counteracting deeper personality integration. They are deterrents to success when relied upon in longer-term psychotherapy. In brief contacts, which are often emergency situations, these forms of greater activity provide the kind of support that allows the individual to put into motion the positive elements of his personality. This increased external support is something like a blood transfusion in a surgical emergency. It allows the reparative, constructive forces of the body to operate. Blood transfusions, however, cannot be relied upon on a long-term basis to take the place of exercise, rest and a wholesome diet. Because of the briefness of psychotherapy, then, the doctor is much more active in interpretation and general supportive measures.

2. *Establish the fact that the therapist is a collaborator.* The patient often regards him as omniscient or omnipotent. Basically, the therapist has two chief qualifications for helping the patient. The first is his experience and training. The second is his relative freedom from emotional involvement in the patient's specific problems, a condition which leaves the therapist's observation and judgment relatively clearer. Establishing the therapist as a man who is a qualified collaborator in the working out of emotional disturbances is an orientation which gives the patient greater self-respect and self-reliance. It also engages him more fully in working out his own problems. He, too, becomes more of a collaborator. He is less the helpless subject, less the mere critic or admirer of the therapist. Furthermore, looking upon the doctor as a collaborator is realistic; the therapist does not know all the answers and requires the fullest co-operation of the patient to be most effective.



3. *Seek the most pertinent and accessible personality difficulty and clarify it.* While related aspects of the problems may perhaps be fruitfully dealt with, it is important to *avoid scattered interpretation*. In the bewilderment accompanying all neuroses, the patient is glad to recognize something real about himself by which to get his bearings. It is important to keep this in focus. Multiplicity of interpretation may produce a current sense of relief, but leaves the patient without direction for the development of further insight. Direction is what he needs desperately.

4. *Avoid interpretative exhibitionism.* It is most important for the patient to sense a sympathetic concern over his difficulties. The atmosphere of the interview is much more conducive to a productive issue, even when the therapist is stumped, if the patient feels his welfare is at stake rather than the therapist's professional prestige. It is important to remember that often little and sometimes nothing can be accomplished in a brief period. It is sometimes judicious as well as kind not to offer an interpretation, even though it may be valid. A neurotic problem represents, not so much a challenge for the right answer, as a cry for help. A tired swimmer feeling himself near to drowning might find greater moral support in a frank, "I can't get to you right away," than from a casual, "What you need is a life jacket."

5. *Carefully evaluate situational factors—by themselves and in relation to trends.* The patient tends to make circumstances the basis of rationalizations or as he calls them when he has insight, "alibis." The fact, however, that a patient uses situational factors as alibis does not entirely cancel their significance. To determine their true significance is part of the job of understanding the total problem and is indispensable in determining action. The patient's rationalization regarding situational factors is used both to avoid responsibility for actions and attitudes and to avoid the imperative to change that comes with insight.

It is important early to raise the question of how far an individual's personality difficulties are the basis of his condition and to what extent hardship is due primarily to situational factors. For example: A man who develops a traumatic war neurosis following a torpedoing may have been quite understandably shaken by the catastrophic nature of the disaster. Equally as disturbing, however, may have been the fact that he had to shout for help, when his personality structure had as a cardinal trend the need to feel



self-sufficient at all times. Reassurance or measures, such as catharsis, taken to eradicate a devastating memory, might be palliative but would have little integrating influence. Some consideration of his need for self-sufficiency on the other hand would give the man a constructive approach to a concrete personality problem. At the same time he would evaluate, in the light of this insight, his reaction to the torpedoing.

6. *Recognize and seek to uncover the basically low self-esteem of all neurotics.* This element of the neurotic personality structure is manifested in many subtle ways, frequently in terms of compensatory mechanisms, such as vanity, hostility, contempt, pugnaciousness, perfectionism. Many patients are totally unaware of their low self-regard; even those who recognize that they feel inferior are seldom aware of how deep the feeling goes and they are never aware of a great variety of ways in which this is expressed. They can usually be shown this uncertainty of their own value in the dependence they have on the opinions of others and in recognition of the ways they strive for approval and to ward off disapproval. They recognize themselves readily in simple figures of speech. For example: (a) Their self-esteem varies in response to outside opinion as a thermometer which rises in an atmosphere of warmth and drops when the surroundings are cool. (b) The neurotic knows that a commodity like wheat does not change in quality with the fluctuating market quotations. Yet, in contrast, as the "quotations" on a neurotic himself rise and fall, he feels almost as if his substance mutates toward the acceptable or depreciates into disposable waste.

A clearer understanding of this low self-esteem makes more intelligible to the patient many of the distortions of interpersonal relationships, compensatory mechanisms, depressions, and psychosomatic letdowns from which he suffers. One of the most important aspects of the gaining of insight into one's low self-esteem is that it lays the groundwork upon which a person can develop a realistic self-respect. Formalistically, this leads directly to another principle of brief psychotherapy:

7. *Analyze clearly the good qualities of the individual.* The neurotic has a very unreal picture of himself. It is usually a derogatory distortion or a compensatory idealization or a combination of the two. Basically he doubts his own value, and either is



not aware of or cannot call his own the positive aspects of his personality. While in general medicine a patient approaches a doctor with the query, "What's wrong with me?" the psychiatric sufferer needs desperately to know what's right about him, too. When he has worked through to some understanding of distorting tendencies that exist in his self-appraisal, he is in a fair position to grasp what he really is. In a more realistic frame of reference, he is prepared to accept, along with his actual defects, his actual assets.

8. *Choose the patient who accepts you.* Whom does one choose for real therapy from among the numerous neurotics who appear in the psychiatrist's office? Youth, good physical status, surmountability of environmental difficulties, these are all favorable prognostic factors. Basically, however, the patient with whom you can go farthest is the one who seeks to understand your language, who looks for your collaboration, who joins in the job you are trying to accomplish. Often it is the therapist's job to discern the signs of such acceptance beneath a resistant or apparently unready exterior. When an individual shows desire or willingness for further work by whatever sign, and even in spite of conventionally unfavorable prognosis, he has designated himself as the therapist's choice of patient.

9. *Refuse to rely on catharsis.* It is necessary in any psychotherapy, brief or protracted, for the therapist to participate every moment. It is true that participation may mean no more than attentive listening. There is a tendency, however, for psychiatrists to take a complacent satisfaction in just listening. Listening is a very large part of the practice of psychiatry. There is less time for it in brief psychotherapy. What the psychiatrist hears may at times lead him to avoid any attempt at treatment. Even that, however, represents an active choice. One must listen well to make such a choice, and must be willing to accept a psychiatric defeat. Most of the time, scrupulous attention leads to perception of personality patterns in scattered analogies, in inflections, punctuations, and style. Clues of this sort are stimuli to further questions or expressed observations, or become mere mental notes for future reference. In brief psychotherapy, because of the limitation of time, greater activity is required on the part of the doctor to keep to the point, to find the point, or to lead to the point. One cannot rely on the slow freight of free association.



Nevertheless, the needed vigilant attention is sometimes absent from an interview. The psychiatrist may listen with eagerness or forbearance to the voluble patient. With kindly and pertinent promptings he may elicit painful intimacies from the reticent. And the patient may gain a significant comfort from feeling safe and expressing himself. The psychiatrist, however, who contents himself with the knowledge that catharsis is beneficial and strives for no more, loses an opportunity to enrich his experience and to increase his skill. What is more, he has abandoned his patient.

#### SUMMARY

The case reported in this paper may be reviewed briefly from the aspect of the principles of brief psychotherapy that were involved. Certainly there was considerable activity on the part of the therapist. A good deal of interpretation was offered directly. Relatively little time was devoted to free association. A friendly, serious, contemplative atmosphere prevailed. Much encouragement was given. Practical assistance was given in making plans for the period following discharge. The positive, admirable aspects of the personality were clearly delineated. As far as choice of patient is concerned, this man received more than the ordinary allotment of time because of his receptivity, co-operativeness and productivity. Productivity was in terms of psychic material and also in terms of his noticeable progress, in his increasing self-esteem, and his deepening social relationships, as well as his approach to the future. The atmosphere of collaboration was early established and the man's own activity was high in spite of the energetic participation of the therapist. Only a few aspects of the total problem were worked on. Such factors as hostility and cruelty were not reached. Low self-esteem, with its concomitant dependence on others for approval, the forfeiture of one's own rights, and the feeling of helplessness were especially emphasized. Interpretation was not scattered over the whole wealth of offered material, and what was given by the therapist was submitted as impressions or "hunches." The patient's painful unhappiness was a source of real and overt concern. He was never left in awe by the exhibition of another's insight, but rather given a hand and kept preoccupied in the development of his own.



These principles of brief psychotherapy do not attempt to cover the whole field. They were formulated in the course of three years of experience in practising brief psychotherapy with psychiatric war casualties from the merchant marine. It is felt that these formulations would apply equally to brief psychotherapy in any setting.

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# FLUCTUATION OF DANISH PSYCHIATRIC ADMISSION RATES IN WORLD WAR II: INITIAL DECREASE AND SUBSEQUENT INCREASE

*(Trends in Psychiatric Hospital Admissions 1939-1948)*

BY B. B. SVENDSEN, M. D.

From the times of Pinel and Esquirol to the present, general interest in the problems of psychiatric statistics has been considerable in most of the civilized countries, although some of the methods and particular topics of concern may have varied. One of the reasons for this interest can be traced to the long-known fact that admissions to mental hospitals may show rather significant variations within any given period of time, thus revealing certain important trends in certifiable morbidity rates.

According to Deutsch, Pliny Earle was the first to stress the need of careful psychiatric statistics more than a hundred years ago. The formulation of such a discriminative approach was an essential part of a plan to replace the then customary "cure" statistics, published by mental hospitals from a strictly competitive point of view and, therefore, often grossly unreliable. The main objective of this new system was, of course, to raise psychiatric statistics to the level of a scientific discipline.

Although the causes of significant fluctuations in admissions to mental hospitals have been subjected to various comprehensive investigations in the United States, they have received relatively little attention in European psychiatry. Of the major American studies, those of Dayton; Landis and Page; Malzberg; and Pollock are particularly worth mentioning. In the Danish literature, statistical problems of this kind have been discussed particularly by Selmer and Hallager.

## CAUSES OF FLUCTUATIONS IN ADMISSION RATES

It is probably correct to say that there are valid reasons for questioning the value of many medical statistics. At least, it is highly unlikely that any of the major enigmas of clinical medicine will ever be solved by statistics, in spite of the undeniable usefulness of "quantitative medicine" in the understanding of the social aspects of disease.



However, we do have statistics, and some system of recording will always be necessary as long as we have patients in our hospitals. Obviously, therefore, significant data accruing in these records should be utilized, especially data which have a bearing on general variations in morbidity.

One essential source of information supplied by hospital records is the registration of admissions. Therefore, a very important question to be raised is: *Why do admissions fluctuate?*

In psychiatry as well as in epidemiology, there has been a tendency to distinguish three types of morbidity fluctuations:

1. *Seasonal* fluctuations, which tend to recur every year;
2. *Short-range* variations, which express themselves within a period of a few years; and
3. *Long-range* variations, which are fluctuations expressible only over a period of many years.

The fluctuations to be discussed in this report are classifiable largely as short-range variations.

The factors responsible for such fluctuations in admissions may be divided into (1) *nosocomial* factors, (2) factors affecting "*the threshold of hospitalization*" (called *threshold factors* hereafter), and (3) factors which lead to *quantitative differences* in the number of mentally ill persons.

*Nosocomial factors* refer to institutional conditions (especially a shortage of hospital beds) which make the number of admissions different from what would be the case, if hospital facilities were optimal. For instance, if there is a shortage of beds because of the prolonged retention of many chronic cases, a decrease in the number of admissions does not necessarily reflect a decrease in morbidity. With respect to mental hospitals, a common nosocomial factor which tends to obscure morbidity fluctuations is constituted by significant differences in the number of transfers from one institution to another.

*Threshold factors* are indicative of circumstances which change the rates of mental patients admitted to hospitals. As a rule, only a certain fraction of psychiatric cases are serious enough to require hospitalization. If this fraction remains constant, an increase in the number of admissions is an indication of increased morbidity, other factors being equal. However, any change in this threshold merely simulates a change in general morbidity rates. Although it may sometimes be difficult to keep these two



sets of modifying factors strictly apart, it should be realized that they are both expedient in general and practically indispensable in an analysis of morbidity fluctuations based on hospital statistics. Unfortunately, there are still many workers in the field of psychiatric statistics, who fail to take these factors into account.

#### CONCEALMENT OF TRUE MORBIDITY FLUCTUATIONS

As an illustration of the effect of nosocomial factors, the number of admissions to Danish mental hospitals is shown in Figure 1 for the periods of 1895-1920 and 1920-1948. Those periods, during which the number of admissions was determined largely by this type of factor, are indicated by a dotted line. It is interesting to note that nosocomial factors lacked significance only during a very brief period, from 1940 to 1945.

In years in which nosocomial factors require the organization of waiting lists because of a shortage of hospital beds, the number of admissions has been shown by Selmer, Hallager, and Landis and Page to be determined by the number of discharges and deaths and by the supply of new beds. Accordingly, the peaks of the curves, which show the rise of Danish admission rates, disclose a striking correspondence with the expansion of hospital capacities and thus reflect the construction history of mental hospitals in Denmark.

The significance of threshold factors is particularly obvious in an analysis of long-term trends, which have always been rising in modern times. The first problem to be considered in such a study is whether an apparently observed increase in morbidity is real or caused by increased hospitalization.

Other factors, which may mask true morbidity fluctuations, may consist of changes in the size of a given population, in age distribution, or in the representation of the two sexes (one of which may be more vulnerable than the other). It is evident that an analysis of basic morbidity fluctuations would be of little scientific value, unless these general population factors were fully evaluated.

Another approach to the differentiation of real and apparent morbidity fluctuations has been suggested by Dahl. According to this investigator, suicidal patients cannot be rejected and, therefore, are independent of the usual nosocomial and threshold factors. If other types of mental disorder tend to fluctuate in a similar manner, the fluctuations may be expected to reflect the same

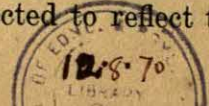
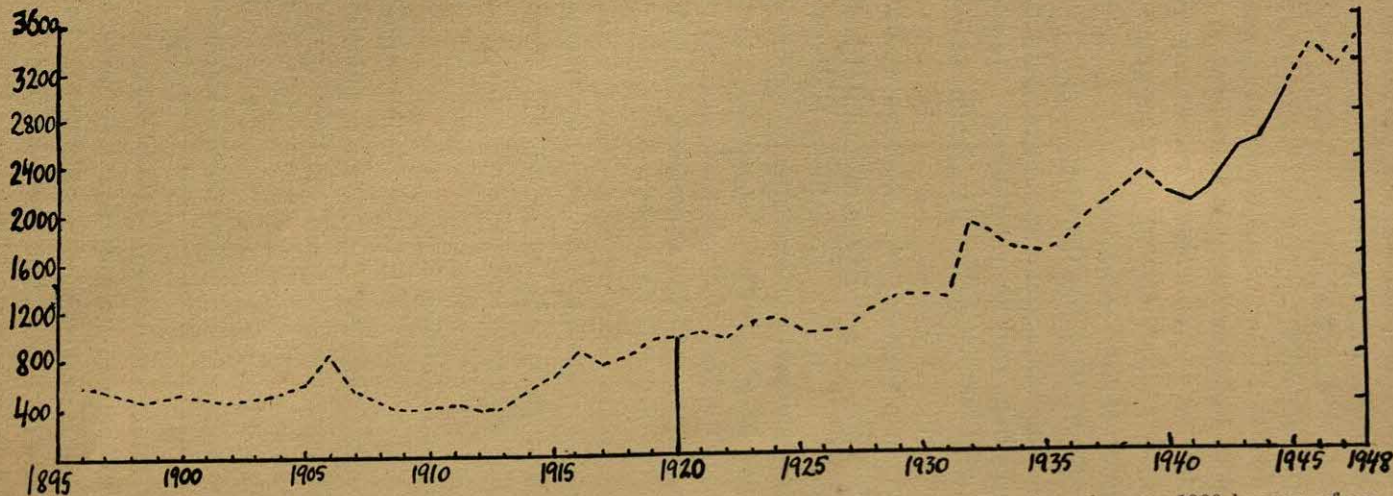




Figure 1. Admissions to Danish Mental Hospitals



Annual admissions to Danish mental hospitals, expressed in absolute figures. Emphasis is placed on the year 1920 because of an increase in population caused by the reunion of Denmark with South Jutland (North Schleswig) which had belonged to Germany from 1864 to 1920.



set of factors that is responsible for variations in attempted suicide.

### CRUDE SHORT-TERM FLUCTUATIONS, 1939-1948

In the decade 1939-1948, the psychiatric clinics available in Denmark had a total of approximately 108,000 new patients. To use this fact for an analysis of short-term variations in morbidity, it is necessary to consider the distribution of psychiatric institutions in the entire country (Figure 2).

Figure 2. Distribution of Danish Mental Hospitals



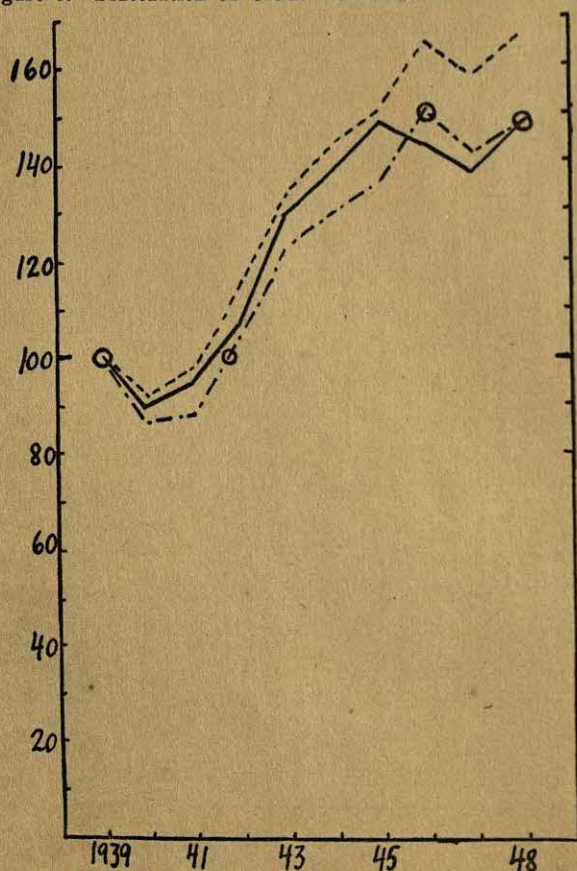
The country's total population (4,000,000) is divided by the Great Belt into two approximately equal sections. The population west of the Belt is served by five state mental hospitals which admit their patients directly. The capital, Copenhagen, is in the eastern area and has four psychiatric clinics for its total popula-



tion (1,000,000). In the remaining area east of the Belt, there are two municipal hospitals which receive patients only through the clinics, and two state hospitals, which take both direct admissions and some transferals from the capital. The only private institution in existence (Filadelfia) has about 150 beds. Altogether, ordinary psychiatric institutions in Denmark (including farm colonies and other branch institutions) have a total capacity of 10,000 beds. In addition, there are special institutions for epileptic and mentally defective patients.

The trends indicated by the crude admission rates for the period 1939-1948 (Health Department Reports) are shown in Figure 3

Figure 3. Fluctuation of Crude Admission Rates 1939-1948



Index values for annual admissions to Danish psychiatric institutions in the period 1939-1948, with the 1939 figures rated as 100: "crude" figures (—); "corrected" figures for all psychiatric institutions (---); admissions to psychiatric institutions with available admission figures for the entire period 1939-1948 (— · —).



with the 1939 rate used as an index, fixed at 100. The fluctuations observed reveal an initial decrease, which came to a stop in 1942, a marked increase up to 1945-1946, and a fairly even level toward the end of the decade. These trends are indicated most clearly by the admissions to psychiatric clinics and to those state hospitals admitting patients directly. Therefore, the present analysis will be limited to these two groups of institutions.

With respect to the operation of *nosocomial* factors within the decade, it may be noted that the period 1940-1944 was distinguished by a rather unusual feature in the history of Danish psychiatry: Neither the state hospitals nor two of the clinics in Copenhagen had waiting lists, although they may have been affected by a sometimes uncomfortable tendency to overcrowding. During the second half of the decade, however, all the hospitals and clinics had waiting lists. One may say, therefore, that there may have been certain modifications of admission rates because of nosocomial factors during the period, although it is apparent that the extent of these modifications cannot have been very pronounced.

The factors which may have affected the *threshold value* are more difficult to evaluate than the nosocomial ones. The main question is whether the decrease observed in admissions during the first part of the decade may have been due only to a rise in the threshold of hospitalization on account of the German occupation. Although the apparent decrease in morbidity was also seen in general hospitals, out-patient departments and private practice, it does not seem very plausible that the morbidity itself was reduced by the operation of some mysterious agent. Instead, it may be assumed that even in the event of illness, many people were induced by feelings of solidarity to stay at home at a time of danger. It is probable, therefore, that the decline in admissions during this period was the result of a raised threshold of hospitalization, partly at least, a universal reluctance to seek medical aid.

It is interesting, however, that the decrease in admissions to psychiatric clinics was almost twice as marked as, and much more prolonged than, that observed in the other medical departments. In fact, the decline in psychiatric admissions extended not only to mild cases, but also to relatively severe ones including cases of attempted suicide. There is reason to believe, therefore, that a relatively high threshold of hospitalization was associated with some real decrease in morbidity during the period.



To determine whether the subsequent increase in admissions (toward the end of the occupation) may have been caused by a lowered threshold factor, it may be borne in mind that the hospitalization rate during the past 50 years has risen for all diseases including mental disorders. It may still be questionable whether there has been a disproportional increase in the incidence of psychoses during this period. It is beyond doubt, however, that both an absolute and a relative increase took place because of increases in population and in its average age.

In mental hospitals, the rate of admissions per 100,000 persons was practically quadrupled from 17 in 1870 to 67 in 1940. Evidently, a certain proportion of this increase was due to a lowered threshold, that is, to an increased tendency to hospitalize relatively mild mental cases. In addition, however, there must have been some real increase in morbidity, especially as the expansion of hospital capacity was always apt to lag behind demand for admission during the period. The assumption of a real increase appears justified, if one compares the line illustrating the average increases in admissions during the period 1920-1939 and the extension (in Figure 1) of this line beyond 1939. The extended line remains below the average line for the years 1940-1942, is slightly above it for 1943 and 1944 and far above during the period 1945-1948. In view of the increase observed in the frequency of suicidal attempts during the same period, it is unlikely that the increased admission rate was exclusively due to a lowered threshold value.

#### STATISTICALLY CORRECTED MORBIDITY FLUCTUATIONS, 1939-1948

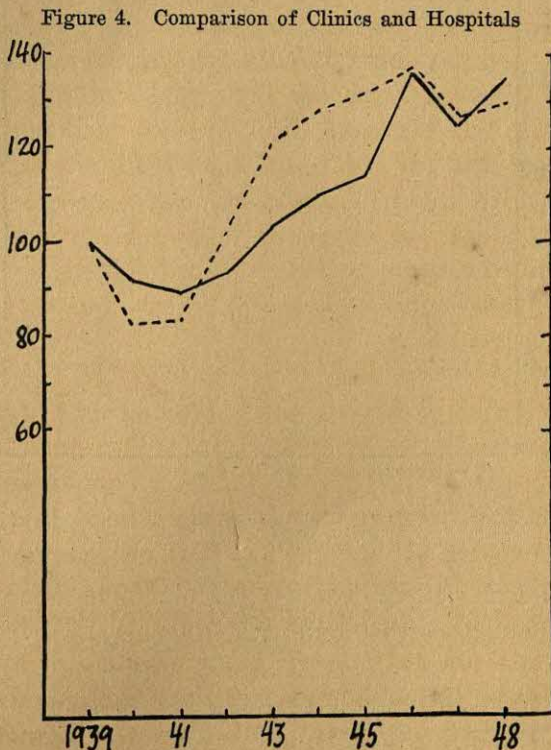
If the crude admission rates are corrected as to transfers, one obtains comparative rates of 7,200, 6,600, and nearly 12,000 admissions for the years 1939, 1940, and 1948. The respective indices are 100, 92 and 166 (Figure 3). In other words, there was an increase of 66 per cent (16 per cent caused by changes in registration, etc., in addition to a real increase of 50 per cent) in the number of mental patients hospitalized within the period of 10 years.

Of this increase, about 10 per cent is accounted for by an increase in the total population, while nearly 40 per cent constituted a real increase (per 100,000 persons). There was no significant change in the sex distribution during the period, and only a minor change in age distribution.



Other determinative influences, which are to be considered in an analysis of the available admission data as illustrated by the fluctuating shape of the previously discussed curve (Figure 3), may have arisen from one of the following four comparative categories: (1) Admissions to mental hospitals and psychiatric clinics; (2) male and female admissions; (3) admissions from different parts of the country; and (4) differences in diagnostic classifications. Unfortunately, no distinction can at this time be made between first admissions and readmissions. It may be noted, however, that the absolute data for the other comparisons have, whenever possible, been converted into rates related to 100,000 persons or to 100,000 males (females) over 15 years of age in the various hospital districts.

1. As far as differences between *psychiatric clinics* and *mental hospitals* are concerned, it is of interest that the decrease in admissions (Figure 4) until 1940 was more pronounced (17 per cent),



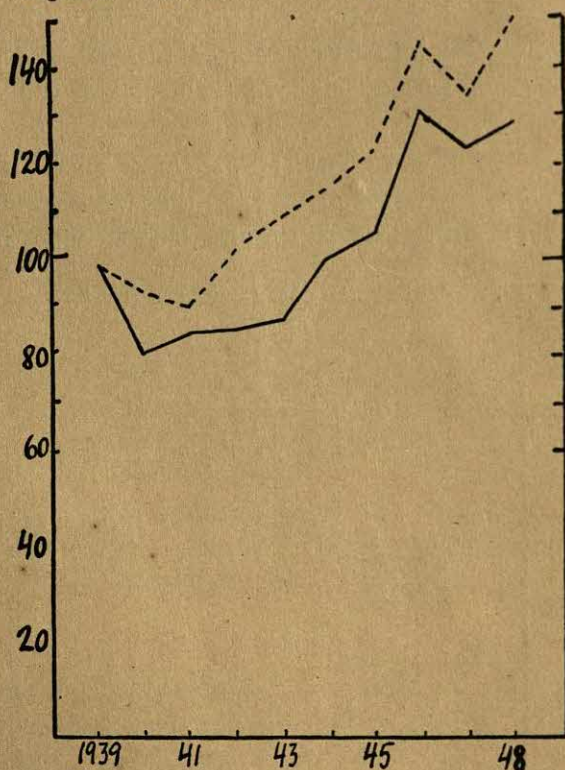
Index values for annual admissions (per 100,000 persons) to psychiatric clinics (---) and state hospitals (—) 1939-48, with the 1939 figure rated as 100.



and the onset of the subsequent increase was earlier and more dramatic, in the clinics than in the hospitals. The duration of the decrease in the latter was prolonged to such an extent that the 1939 level was not essentially surpassed until 1946.

2. A comparison of male and female hospital admissions (Figure 5) reveals that the initial decrease was preponderantly male (20 per cent in 1939-1940) and lasted until 1944, while the subse-

Figure 5. Sex Differences in Hospital Admissions

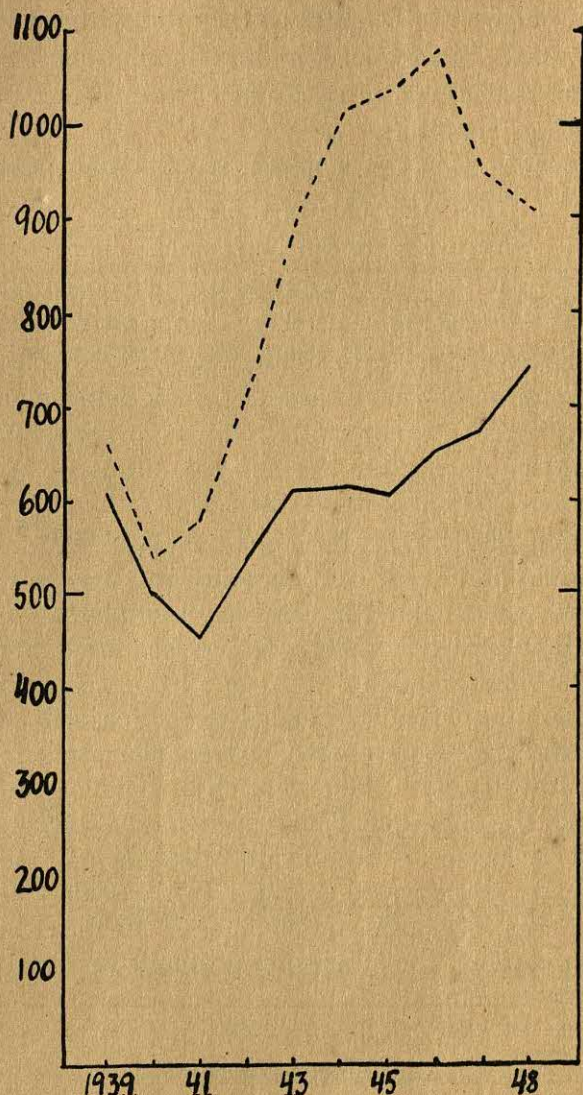


Annual male admissions per 100,000 male persons over 15 years of age (—) and the corresponding female rates (---) for mental hospitals 1939-1948.

quent increase was preponderantly female. The clinic admissions (Figure 6) showed corresponding differences, which were even more pronounced. There was a 62 per cent increase in female admissions from 1939 to 1946, and the sex difference would have been even higher without a statistical correction, which has been made for the known preponderance of the female sex in the population of Copenhagen.



Figure 6. Sex Differences in Clinic Admissions



Annual male admissions per 100,000 men over 15 years of age (—) and the corresponding female rates (---) for psychiatric clinics of the Copenhagen City Hospital and the Bispebjerg Hospital 1939-1948.

3. Since every institution serves a different district, a *regional* analysis can be made for the mental hospitals. Of course, the trends in the Copenhagen population practically duplicated those observed in the psychiatric clinics.



Outside of Copenhagen, the hospital admissions varied almost as much from hospital to hospital as they did within each hospital from year to year. Since the individual fluctuations were not consistent, it is possible only to speak of certain general trends for various groups of hospitals.

The western hospitals as a whole had an initial decrease in admissions, with a preponderance in the male sex, while the subsequent increase was preponderantly female. The corresponding variations in the two eastern hospitals were so obscured by extrinsic factors that they cannot be used for comparative purposes. The fluctuations observed in North Schleswig differed to some extent (prolonged decrease and no excess of female admissions over the 1939 level until 1945), among other things probably because extensive emigration during the German rule (1864-1920) led to special conditions in this borderland district.

4. Variations in relation to *diagnostic* classifications are to be interpreted with the utmost caution, since it is known that psychiatric diagnoses are affected by various administrative imperfections and regional idiosyncrasies. It may be stated, however, that the decrease in admissions observed in all the western and one of the eastern mental hospitals extended to the majority of the main diagnostic categories (psychoses, psychoneuroses and psychopathic personalities), with the exception of female psychoses. On the other hand, the subsequent increase was due largely to female neuroses and psychoses, especially to "situational" ones. During the entire decade, there was a decrease in the schizophrenic rates, apparently because of significant changes in the diagnostic criteria used. By comparison, the admission of manic-depressive patients remained fairly constant.

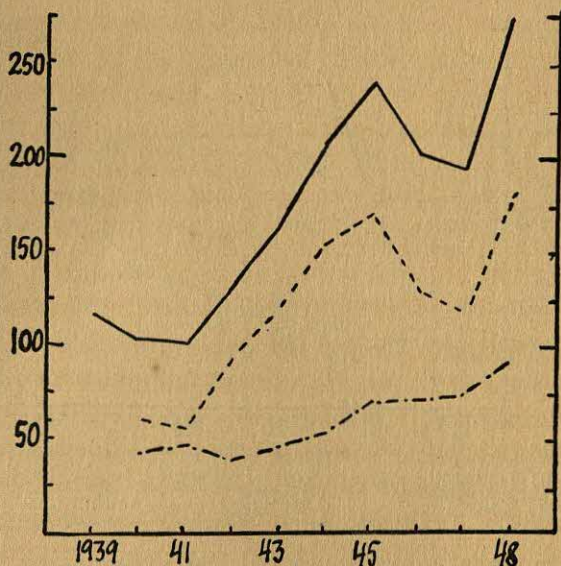
With respect to admissions to psychiatric clinics, it seems advisable to use the absolute figures for the Copenhagen University Clinic, although it has been impossible to convert them into rates per 100,000 persons. As to diagnostic categories (psychoses, neuroses, psychopathic personalities, oligophrenia, mental disorders in children, absence of any mental disorder, and attempted suicide), the admission rates of this clinic showed an initial decrease, which lasted until 1941 and affected all the main diagnostic groups, except that of oligophrenia. The subsequent increase was distinguished by three different trends:



(a) The admissions of oligophrenics and psychopathic personalities were characterized by an increase, which was limited to the war years 1942-1944 and revealed an excess of females. Since the end of World War II, the admissions of oligophrenics to psychiatric clinics have decreased steadily.

(b) Suicidal attempts (Figure 7) showed an increase, which reached its peak only in the years 1944-1946 and was followed by a moderate decline in the most recent years (except for 1948). The rise in the male suicide curve was quite consistent, while the female rate revealed a marked increase toward the end of the war.

Figure 7. Admissions of Attempted Suicides to the Copenhagen University Clinic



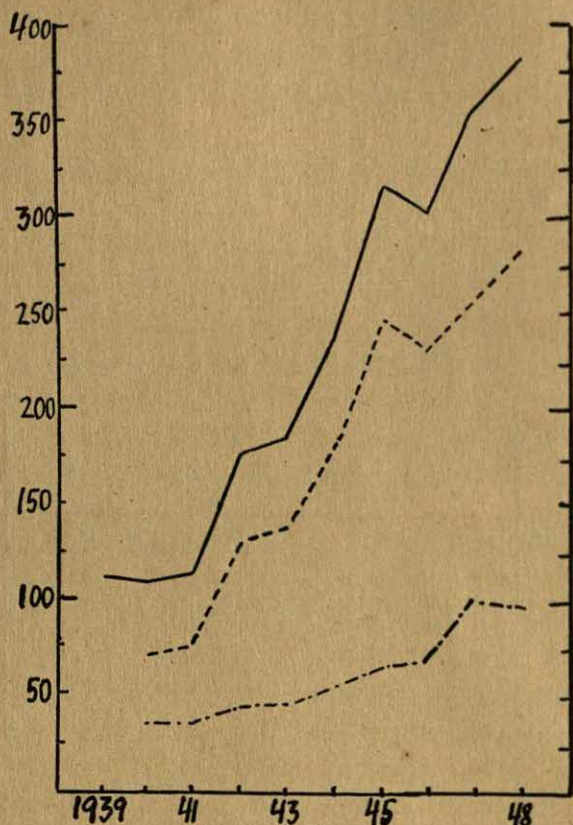
Annual number of attempted suicides (absolute figures) admitted to the psychiatric clinic of the Copenhagen University Hospital in the period 1939-1948; males (— — — —), females (— · —), and all admissions (——).

(c) The other diagnostic categories—psychoses, neuroses (Figure 8) and absence of mental disorder—were distinguished by a marked increase during the war years, which continued into the postwar period. The increase in the female rates during the period was particularly excessive with respect to the last two categories (300-400 per cent).

Of course, the category of greatest psychiatric interest is that of apparently reactive psychoses, especially reactive depressions and other situational reaction syndromes (Figure 9). In this category,



Figure 8. Admissions of Neuroses to the Copenhagen University Clinic



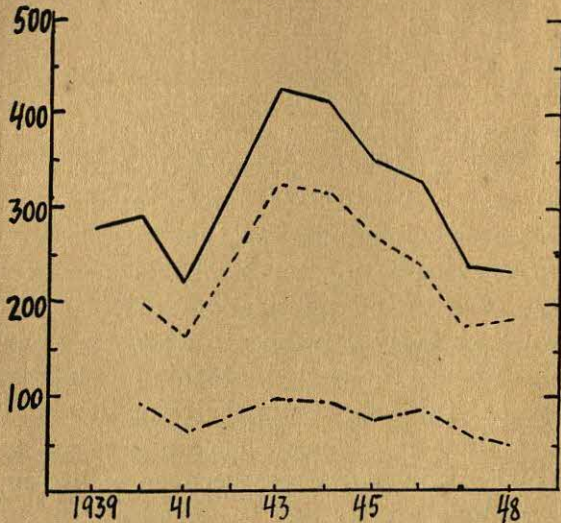
Annual number of neuroses (absolute figures) admitted to the Psychiatric University Clinic 1939-1948; males (---), females (-.-), and all admissions (—).

there was a moderate decrease until 1941, which was followed by a sudden rise in 1942-1943 (exclusively caused by female admissions and resulting in a virtual doubling of the total rate) and by a gradual decline in the remaining years till 1947-1948.

In addition, it may be mentioned that senile psychoses showed a slight and rather irregular increase. Parenthetically, it may also be recorded that in the years 1940-1946, there was an 800 per cent increase in the number of cases admitted for the purpose of having early pregnancies interrupted. In 1946, about 150 per 100,000 females over 15 years of age were admitted for this purpose in Copenhagen. In approximately one-half of this special category of hospital admissions therapeutic abortions were performed.



Figure 9. Admissions of Apparently Reactive Psychoses to the Copenhagen University Clinic



Annual number of patients (absolute figures, 1939-1948) admitted to the Psychiatric University Clinic with psychoses classified as reactive (situational); males (— — —), females (- - -) and all admissions (——).

#### SPECIFIC CAUSES OF THE RECORDED VARIATIONS IN ADMISSIONS

An attempt to correlate the variations observed in admission rates with any of the usual factors presumed to have a bearing on psychiatric morbidity (such as epidemics, total mortality or fluctuations in unemployment) has been entirely unsuccessful. It seems reasonable, therefore, to consider those particular changes in the emotional atmosphere, which were brought about by World War II.

Without much preceding warfare, Denmark was occupied by German troops on April 9, 1940. At the outset, life under the conditions of occupation was remarkably undisturbed. However, as general feelings of insecurity established themselves and personal anxieties concerning the future became intensified, a growing antagonism between native population and occupation forces developed. In 1943, the elimination of the Danish government was followed by increasing German terrorism (mass raids, arrests, deportations, bombings and retaliatory "random" executions as punishment for sabotage).

As a result, the Danish people became more and more unified. In contrast to certain pre-war signs of withdrawal and indiffer-



ence, they demonstrated a growing interest in political events and a compensatory pride in the cultural heritage of an old nation fighting for its survival. To the same extent as was observed in other countries by Abély, Gillespie, Hemphill, Hopkins, Lewis, Saethre and others, the unusual political circumstances resulted in a real decrease in psychiatric morbidity rates. This decrease was associated with a temporary rise of the threshold of hospitalization (1940), partly because of deteriorated traffic conditions.

Some of the increase in admissions that was observed during the second part of the occupation was probably ascribable to the immediate effects of growing political terrorism. However, equal importance was evidently attached to a severe disintegration in family relations during the period. Many men left their homes to accept employment far away from their families or to escape arrest and deportation. The consequence was that women were exposed to unusual strain and stress because of broken homes, disappointments in love affairs and the need of self-support under difficult conditions of housing. It was no surprise, therefore, that the increase in reactive mental disorders was more or less limited to the female sex.

The increase in morbidity, which occurred after the liberation of the country, was apparently caused by a general "let-down" in the emotionality of the people. A sudden relief from prolonged tension was calculated to contribute to the development of psychotic reaction syndromes.

#### PRINCIPAL RESULTS AND CONCLUSIONS

The initial decrease in admissions to Danish mental institutions, as observed during the first two years of the German occupation (1940-1941) and summarized in Figure 3, may be attributed in part to an increased threshold of hospitalization and in part to a real decline in psychiatric morbidity rates. This decline was especially pronounced with respect to reactive mental disorders and favored the male sex, apparently as the result of general psychological reactions to the occupation.

In the years 1942-1945, there was a 50 per cent increase in admissions over the 1939 rates, mostly on account of a marked rise of situational reaction syndromes in women (disintegration of family life caused by the hazardous conditions of occupation). That this increased demand for hospital beds could be accommodated—



in spite of the growth of the total population and of a gradual decline in the threshold of hospitalization—was made possible by a reduction in the duration of hospitalization following the introduction of shock treatment rather than by an expansion of hospital facilities as has been maintained by some writers.

During the last three years of the period investigated (1946-1948), psychiatric admission rates returned to a relatively even level, and mental hospitals moved again into the shadows cast by a perennial shortage of beds. This deplorable state of affairs obviously called for a well-planned expansion of the total hospital capacity, but has been perpetuated by the repercussions of the current economic situation of the country.

*In conclusion*, it may be stated once again that a great number of general statistical factors must be taken into account before it is permissible to infer real fluctuations in morbidity. Apart from significant variations in total population size and in the particular aspects of its age and sex distribution, there are three sets of factors which may be responsible for changes in admissions to mental institutions:

- (1) Nosocomial factors, which refer to the effect of inadequate hospital facilities, especially to a shortage of hospital beds. If admissions are delayed by the existence of a waiting list, their variable rates are largely determined by the number of discharges (including deaths) rather than by fluctuations in morbidity.

- (2) Factors which change the threshold of hospitalizations and thereby modify the proportion of mental patients requiring admission. Evidently a lowered threshold tends to simulate an increased morbidity rate.

- (3) Factors which cause real changes in the number of mental disorders in a given population and, therefore, modify the number of cases requiring psychiatric aid in clinics and mental hospitals.

An analysis of Danish admission rates for the years 1939-1948 reveals that *true morbidity fluctuations* occurred in the Danish population during the period, apparently under the impact of the German occupation and irrespective of the effect of other modifying circumstances, the proportional significance of which has been evaluated for each set of factors.



In recent years, however, the usual conditions prevailing in the care of mental patients have re-established themselves in Denmark, due to a deplorable, but at present financially unconquerable, shortage of hospital beds.

#### ACKNOWLEDGMENT

The writer takes pleasure in acknowledging that he is indebted to Drs. N. D. C. Lewis and J. Zubin of Columbia University and the New York State Psychiatric Institute for valuable suggestions in relation to the arrangement of this report. He also is very much obliged to Dr. F. J. Kallmann of that institute for his very careful revision of this manuscript.

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## VALIDATION OF LIBIDO THEORY\*

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Presenting material relating to a disputed theoretical subject—a specific problem in psychoanalytic psychology—without sufficient space to develop the necessary historical background and the proper frame of reference, invites misunderstanding and misinterpretation. However, the problem may be overcome in part if the clinical material is grounded in an area already familiar to the reader. With this objective, observations made on patients where the physiologic participation in fantasies and emotional attitudes was particularly lucid have been selected for presentation here.

Validation of a psychologic theory requires more than clinical usefulness. Concepts may have to be modified repeatedly, or even rejected, in the light of new facts derived from additional studies. It is especially desirable to be able to gain support for such a psychologic theory from related fields which are in a more advanced state of scientific development. Psychosomatic disorders, by their very nature, provide an effective linkage between psychologic and physiologic phenomena. Clinical observations at an organ-functional level may be directly correlated with subjective statements concerning thoughts, fantasies and affective states, and thus serve as proof or at least as highly suggestive indicators of validity of a theory.

The dynamic concept of instinctual drives and its extension in libido theory form one of the fundamental contributions of Freudian psychology. We are aware that we do not perceive instincts as such; we cannot describe an instinct or measure its quantitative impulse or direction. It is primarily through the manifestations of these instinctual drives at a behavioral level that we are able to infer, or, by a process of extrapolation, evolve the characteristics of these instinctual forces.

Where does this driving force come from? Where does this energy which is associated with the manifestations of instinctual drives come from? In one of Freud's earliest papers he pointed out that we must eventually go back to the biochemical basis, to the biological constitution of the individual, to find the source of these "urging energies." The several tissues and bodily organs

\*Read before the bimonthly conference of the New York State Department of Mental Hygiene, Gowanda State Hospital, Gowanda, N. Y., June 19, 1951.



constitute the matrix in which energies or drives are generated. The expression of these urges to action may be noted in behavior which involves certain areas of the body or in symptoms. Sexual or libidinal drives characteristically become attached to several prominent areas referred to as erotogenic zones. The physicochemical economy of the body, which is the source of instinctual energy, may utilize such zones as the mouth, anus and genital area to achieve expression. The particular form of behavior, or the channel selected for instinctual gratification, depends upon a multitude of individual determinants as well as upon sociological and cultural factors.

It is noteworthy that the commonly favored erotogenic zones of the body are typically areas where skin and mucous membranes meet. It is this particular type of junction which seems to have special characteristics in terms of potential capacity for arousing intense feelings and emotions. These areas may be looked upon as orifices and are for the most part external. They can be manipulated, and such stimulation not infrequently is associated with a pleasurable feeling tone. Furthermore, symbolic values and associated fantasies may be related, in one's thinking, to such areas and thus enhance the feeling. A common example would be masturbatory activity involving a particular part of the body and the increase in gratification experienced when a desirable fantasy accompanies the act.

Not only stimulation *per se* but a certain type of characteristic stimulation seems to have additional value. For example, a rhythmic type of stimulation rising in crescendo-like form to a peak has particular excitatory value.

Under special conditions such as surgical intervention, parts of the body not ordinarily exposed are brought to the surface, a mucocutaneous junction is formed, and its erotic significance may be evaluated. This provides the opportunity to study the psychophysiology of such an organ. Furthermore, the individual is in a position to become more aware than previously of local reactions and subjective experiences. He can now see, touch, and feel the newly exposed part. Observing changes in its form and color as a result of manipulation or personal fantasies leads to a much more vivid type of subjective description. This is a new organ, not subject to taboos or inhibitions that may have been associated with other parts of the body.



In the two cases to be presented, it is of interest to note not only the patients' experiences but how others who came into contact with them reacted to their behavior, often without realizing what was annoying them.

The first patient was a 36-year-old man who was admitted to Mount Sinai Hospital, New York City, in March 1947 with a 17-year history of ulcerative colitis. His original admission in 1930 occurred shortly after his mother's hospitalization for hysterectomy. At that time he complained of bloody, loose bowel movements, abdominal cramps and a weight loss of 40 pounds. During his hospital stay, the diagnosis of chronic, nonspecific ulcerative colitis was confirmed by x-ray and sigmoidoscopic studies. Blood agglutination tests for specific dysentery organisms were all negative. No ova or parasites were found in the stools. The hemoglobin had fallen to 42 per cent. Medical treatment with opiates and repeated transfusions led to marked improvement with relief of abdominal pain; a 13-pound weight gain, and an increase in hemoglobin to 68 per cent. The appearance of the mucous membrane on sigmoidoscopy was almost normal.

About six months later, this man was readmitted because of migratory polyarthritis and a recurrence of bloody diarrhea. He again responded to medical therapy and was fairly well for a period of 11 years until his first child was born. He related minor exacerbations to situations of emotional strain and also reacted to the birth of his second child with a temporary return of symptoms. His admission in 1947 was occasioned by severe diarrhea, with 20 to 25 watery bowel movements daily, accompanied by intense abdominal cramps. Examination revealed widespread involvement of the rectum, sigmoid, and distal end of the descending colon. Sigmoidoscopy revealed thickened, granular, friable mucosa, covered by a purulent exudate. Medical therapy was of no avail. He was transferred for further study, to the psychiatric ward, where it was decided that an ileostomy should be performed. This he refused, saying he didn't want to be cut—he didn't want to have an opening in his abdomen. He preferred to take his chances on living with his colitis rather than submit to operation.

Psychiatric investigation disclosed that this patient was an only son and that, soon after his birth, his father had emigrated to this country alone, the baby then had developed an unusually close emotional relationship with his mother. He was a bed-wetter until



the age of five. When the boy was eight, he and his mother rejoined his father; and he thenceforth felt neglected and deserted by the mother who no longer gave him the tender, loving care he had previously received.

As a youth, the patient's college career was interrupted by his first illness and was never resumed. Sexual education had been neglected at home; and most of the boy's information was gathered from his playmates. Masturbation with heterosexual fantasies began at 13 and persisted until 18, when it was discontinued because of increasing guilt feelings. He avoided girls because of an exaggerated fear of syphilis. A year later, and corresponding to the time of his mother's hysterectomy, his initial symptoms appeared.

The patient's first marriage, at 25, to a neighborhood girl, was loveless and lasted for but one month. He had apparently married her to show his gratitude to the girl's mother for saving him from gas asphyxiation when he was nine. After three years he remarried, this time without the recognition of the church. He expressed the belief that the rectal bleeding was a form of "purification for the sin of remarriage." His second marriage was stormy, with frequent interference from his mother-in-law, who insisted that her daughter have an abortion soon after the marriage. This was done without the patient's knowledge or consent; and he afterward distrusted his wife, which led to bitter quarrels. Following the birth of the first child, his wife was compelled to work, and his mother took over the care of their child.

The patient was always perfectionistic, neat and meticulous, and was constantly concerned with finances and social acceptability. He was given to outbursts of rage against his wife and father; but these were never directed against his mother. He maintained an infantile, dependent relationship toward her, repeatedly seeking her attention.

Finally, after considerable indecision, he agreed to the ileostomy if he could have the privilege of returning to the psychiatric ward shortly after the operation. He wanted the psychiatrist to look after him through this difficult period. (He stayed, however, on the surgical service.)

At operation, the diagnosis was confirmed with the addition of marked inflammation of the transverse colon. Following the operative procedure, he responded with a prompt subsidence of fever,



and began to gain weight. He remarked that he felt fine, and was in good spirits. There was a slight amount of bloody drainage from his rectum, but this cleared up after a few days.

Following recovery from the ileostomy, the patient insisted on taking care of the stump himself, maintaining scrupulous cleanliness with neat applications of an aluminum paste to the surrounding skin. The surgeon who operated on him would demonstrate the patient "on grand rounds" as an example of the proper way to take care of an ileostomy. He seemed to spend considerable time cleaning the ileostomy and applying fresh dressings. When, as part of the usual procedure, he was approached for a fitting for an ileostomy bag he refused to have one. He stated that he did not want a bag—that he preferred to continue taking care of it himself as he had been doing.

At the time of the operation about two inches of ileum was delivered through the abdominal opening to allow for subsequent contraction. On one occasion, the patient spontaneously asked the psychiatrist if he wanted "to see something." He retreated behind closed curtains around the bed, removed the dressing and began rubbing the protruding ileum with a gauze pad. As he did so, he smiled and appeared to enjoy watching the piece of small intestine. The ileum, which was flabby and pink, became more engorged with blood and took on a bright red hue. In addition it contracted and became stiffer; and after a short while, fecal contents began to flow out of the opening. When he was asked what this was all about, the patient laughed out loud and said, "You know, like when you rub down here"—pointing to the genital area. In response to further questioning, he indicated that the feeling was of a similar type, and that rubbing the ileum gave him a markedly pleasant sensation. He didn't mind at all the job of cleaning the area, perhaps a dozen times a day.

Interestingly, the nurses became annoyed with this man. When asked why they seemed to dislike him, they were vague, and could only answer that "he spends so much time 'fooling around' with his ileostomy." They felt there was "something peculiar" about it; and for some reason, which they were unable to verbalize, they just didn't like it. When pushed for a more adequate reason, one of the nurses put it on an economic basis: "Look at all the pads of cotton he's using. We can't keep getting him pad after pad."



During the patient's previous stay on the psychiatric service, he had struck up a close friendship with an orderly who had homosexual inclinations. This orderly regularly visited the patient on the surgical service, where he was finally content to remain, despite his previous insistence on returning to the psychiatric ward. At first, he seemed to enjoy the orderly's visits; but after a while he asked the psychiatrist to keep this fellow away. When his wife came to visit he would at some time during her stay, draw the curtains around the bed and enlist her aid in cleaning the ileostomy and changing the dressing. He was perfectly capable of doing it himself, yet every visiting hour was the signal for the two of them to work over him. The nurses insisted that he stop this during the visiting hour and wait until the visitors left.

Following this edict he seemed to lose interest in his wife's visits but he struck up a close relationship with a 19-year-old boy who was ambulatory following an appendectomy. The two of them would work on the ileostomy together.

His appetite was voracious, and he gained about 20 pounds in a few weeks. During one of the talks with the psychiatrist, when discussing the return of his appetite, the patient volunteered that he liked to eat, and added: "It gives me more stuff to come out"—referring to the ileostomy.

With the passage of time, the ileostomy became more everted and began to retract a bit, as had been expected. It seemed to be getting smaller and shrunken. The patient asked to see the psychiatrist as soon as possible when he noticed this. With considerable anxiety, he indicated what had happened and asked. "It won't get any smaller, will it?" He appeared to be considerably upset about this occurrence. The obvious relationship between the degree of manifest anxiety and his undue concern about the size of the stump, regardless of the fact that it was functioning satisfactorily, was impressive. This patient carefully observed every little change in the protruding portion of the ileum.

It is apparent that this man was treating his ileal stump as a displaced genital organ and that he derived an orgasmic type of pleasure from manipulating it. Unless one knows more about his early psychosexual development, it is hard to understand why he could not indulge in direct masturbatory activity. Without going into too many details, the patient was able to recall being caught handling his genitals by his mother when he was about five years



old. It was at this time that he was very close to his mother, who reciprocated his affection. Her husband was away, and she naturally invested her deepest affections in her son. While he was not aware of a desire to replace his father or of any outspoken incestuous fantasies, his dreams indicated the presence of such unconscious drives. With the recurrence of masturbation in adolescence, he was aware of deep guilt and anxiety. Even in intercourse with his wife, he had occasional periods of impotence. It appeared that almost any kind of genital sexual activity was laden with considerable anxiety. Concomitant with this, he expressed exaggerated fears of syphilis and he was deeply afraid of suffering some injury to his genital organ. The need to regress, as part of a defensive maneuver, to pregenital interests and homosexual or auto-erotic practices is now more comprehensible.

The genital area was, as it were, forbidden soil. It was a part of the body that was directly involved with his guilt feelings. However, when he received a new organ to play with—one which did not have any religious, cultural or personal taboos associated with it—he could then allow himself free indulgence. Here was a new opening from which he received gratification without any qualms. On the contrary this was an organ, given to him with the surgeon's blessings, which he had to touch, rub and keep clean. As a matter of fact the more "he fooled around" with it as part of keeping it clean and neat, the greater approval he received on grand rounds.

In a classical paper written in 1910, entitled, "Psychogenic Visual Disturbances According to Psychoanalytical Conceptions," Freud pointed out that when an organ is used for an erotic gratification, it will tend to interfere with its normal physiological functioning. He stated: "It is never easy to serve two masters at the same time. . . . When an organ which serve two purposes overplays its erotogenic part, it is in general to be expected that this will not occur without alterations in its response to stimulation and in innervation, which will be manifested as disturbances of the organ in its function as servant of the ego."

Experience with this patient tends to confirm and validate the concepts of displacement of libidinal energy and the fact that various parts of the body or various organs may become erotized. There is little doubt that, both objectively as well as from the standpoint of the patient's subjective experiences, the ileal stump behaved like a genital organ and was associated with characteristic



fantasies related to such organs. This man has since had a sub-total colectomy with further improvement.

The second patient was a 36-year-old lawyer who first came for psychotherapeutic treatment approximately six years ago because of intermittent and varying degrees of impotence. He wished to get married and was financially capable of doing so but was afraid that he would not be sexually competent.

He was an only child. Prior to his birth, his mother had had several spontaneous abortions; and she was 40 years old when she finally gave birth to this child. He was breast-fed until nine months of age. As a child, he was always meek, passive and proper and did excellent work in school. He was the pride of his family. As he talked about his early life, it became apparent that he was a severe compulsive character, who, in addition, had certain neurotic symptoms of an obsessive-compulsive variety which complicated his ability to get his work done.

The following information came out over a period of a year and a half of analytically-oriented psychotherapy during which the patient was seen once or twice a week. He recalled that at four to five years of age, he would often take naps with his mother, on which occasions he would suck at his mother's breasts. His mother did not seem to mind, and, on the contrary, seemed to be enjoying the procedure. Despite this, he recalls that he would always be afraid of his father coming home; and such activity was always indulged in long before the time arrived for his father to return from business.

Further indications of oral interests came out in the fact that he was a finger-sucker, using the third and fourth fingers of his left hand, until he was six years old. He indulged in this rather persistently so that he first distinguished left from right by the teeth marks on the fingers of his left hand. This was a big joke in the family.

He bit his fingernails until he was 14, after which he first stopped and then resumed the habit on various occasions. It was at this age that he first began to have symptoms of colitis.

His memory for the events of his early life was rather good, but as he talked about them, he showed relatively little emotional excitement. He seemed to dissociate intense feeling from these memories, with the latter remaining quite clear. He recalled defecating, at four years of age, under the front porch in company



with the maid's daughter who was about the same age. He felt rather excited about it, even though at that time he knew it was something to be hidden because it was wrong. At seven or eight, he had repetitive nightmares having to do with piles of coal which he equated with feces.

In his pre-adolescent years—up to 12—he thought of the female organ as being “a dark brown hole in the abdomen.” Associated with this, he had a fantasy of putting his penis in a neighbor girl's umbilicus.

Genital masturbation began at 12, but without ejaculation. Concurrent with this, he first experienced abdominal cramps. When he complained of abdominal pain, he would lie in bed, and his mother would rub his abdomen. This invariably resulted in relief of the pain. At this time he had a fantasy that his mother would invite him to have intercourse with her, but the boy never made any advances along these lines. His abdominal pains continued intermittently until he was about 14, when he was sent to a camp for the summer. While there, he began to have severe diarrhea with 15 to 20 bloody stools a day and a loss of 25 pounds in weight. He was brought home, and an appendicostomy was performed.

Following the operation he went to the country with his mother, the father remaining at home. He and his mother shared one room in which they had twin beds. His mother was extremely nearsighted as a result of severe diabetes. When she would take off her glasses she could hardly see beyond the tip of her nose. On many occasions while his mother was in one bed, without her glasses, although still awake, and he was in the other, he would masturbate without ejaculation. He recalled that his penis was so small at the time that he could only use two fingers to masturbate. It was with envy that he often thought of the large size of his father's penis.

On one occasion when he was masturbating vigorously, he evidently hurt or irritated himself and he noticed some bloody fluid coming out of his penis. He became extremely frightened and stopped genital masturbation immediately. Since he then had an appendicostomy he began to focus considerable interest on this opening. He would squeeze the appendicostomy from all different sides in an effort to clean it. He would squeeze and squeeze in order to get the last bit of feces out from the opening. He remarked that this gave him a pleasurable feeling and had a certain



tickling quality. This he would do in front of his mother even when she was wearing her glasses. When she would insist that he stop, that he was going to irritate the opening, he would rationalize his behavior by saying that he wanted to get all the feces out and keep it clean.

When he was 15, an attempt was made to close the appendicostomy but the closure would not heal. He developed a fistula, and it kept draining. This frightened him considerably since he felt that he must have injured the appendicostomy in some way with his repeated manipulations. It remained open for a full year and, interestingly enough, began to close at a time when he began to indulge again, in genital masturbation which now was accompanied by ejaculation. Even though he had considerable apprehension concerning auto-erotic practices, in terms of "causing insanity" or permanently injuring his genitals, he continued masturbation for many years.

It was not until he was 27 that he had his first heterosexual relations with an aggressive girl who made the advances and really seduced him. He was troubled by ejaculatio præcox and, not infrequently, was unable to maintain an erection. At the times when he was successful in completing coitus, he still felt the urge to masturbate following intercourse, because the latter did not completely satisfy him.

During this same year, his mother developed a severe itching neurodermatitis involving her whole body. One day he "happened to walk into his mother's bedroom" at a time when she had her genitals exposed and was scratching herself. He was struck with a terrific sense of revulsion and disgust at what he saw, but the vivid quality of this incident remained clearly in his mind.

The following year his mother became severely depressed and committed suicide. When this occurred, the patient's father was broken up about it and wanted the patient to sleep with him. He felt squeamish about doing so but nevertheless did go to bed with his father. One night his father's penis accidentally rubbed up against him and the young man became so panic-stricken he practically jumped out of bed. His father then began to make increasing demands upon him to come home for dinner, to spend the evening with him and to go visiting with him. The father became extremely possessive—to the point where the patient would have to break dates with girlfriends in order to keep his father company.



He experienced considerable guilt feelings when he would become aware of wishing that it was his father who had died in place of his mother. He discussed many passive homosexual fantasies of this period.

Improvement under psychotherapy was progressive, with a decrease in his obsessive-compulsive tendencies. He was able to open his own office, had many dates with girls, and impotence was no longer a problem.

He was working long hours when he contracted tuberculosis and had to be hospitalized and placed on bed-rest. He did not respond well and pneumothorax and finally a thoracoplasty were performed. During this period he communicated with the writer by letter. He had a severe cough and received considerable amounts of codeine to diminish the cough reflex. He wrote in part, as follows:

"I have been meaning to write you for several weeks, but I have been procrastinating, probably because the whole subject matter is unpleasant to put down on paper, especially the latter half." In the letter he went on to tell how his tuberculosis was improving with streptomycin, codeine and the operative procedures. He had been told that the codeine would probably constipate him and that he might have some diarrhea when the drug was discontinued. Accordingly, it had been discontinued slowly. Despite this, he began to have severe diarrhea with blood and pus in his stools. He wrote, "When I first became sick I was warned that the codeine I was taking would result in constipation. It did a bit but not seriously. About a month after I first took sick my t.b. doctor took the codeine away. At once my bowels became loose, and this condition became progressively worse until I was having six or seven very watery stools a day, together with much gas, some blood, and distress.

"I have always been permitted toilet privileges, and this walking back and forth was pretty exhausting. The doctor said that diarrhea or constipation was not unusual with tuberculosis patients and treated my condition first with boiling my milk, then by giving it to me warm, then he gave me a medicine containing pectin, then bismuth powder, and then a tablet that I don't know the name of, all of which time I was also taking about a quarter of a grain tablet of phenobarbital three times a day. He also put me back on codeine but nothing would help."



However, after about two weeks his colitis improved and he began going to the toilet only about two or three times a day, "I had less gas and pain; the quality of the stools stayed loose and watery but this was a great improvement. "Please remember," he writes, "the point at which I got better. It is seven or eight days ago now, and it will tie in with what I will tell you later."

Strangely enough, he lost relatively little weight—only about four pounds. "And now I have to go back to the beginning again." He continued, "Right from the beginning, I gave up smoking with no effort and have had no strong desire to smoke again. I used to smoke two packs a day. I have stopped completely and have no desire to start that again.

"I had been quietly congratulating myself on both accomplishments and wondered if it would continue thus once I was out of bed and back in a normal life again. In the beginning I also had a worse-than-usual fear of wet dreams, because of the daily visits of the visiting nurse. She used to come in to give me the streptomycin. I also used to worry as to whether I would get an erection during my bath from her, and I would worry about strange nurses coming in.

"I soon discovered, however, that I was completely asexual—that is, no sexual interest at all. I apparently had repressed everything so that I had no fantasies or anything of that sort at all.

"I would skip over parts in books that I was reading describing about screwing, and so on, just so as to avoid fantasy. I put the fact of no wet dreams up to my weakened condition. Then about two weeks ago I suddenly remembered you had once remarked something like, Where does the libido go?

"Then I began to wonder if my libido hadn't gone from my penis to my colon. I wondered if I could bring it back, and whether that would cure the colitis. I tried deliberately to have sexual fantasies, with only fair success, with A [she was the first girl with whom he had had sexual relations].

"Then last week, the date or point I mentioned before, I masturbated twice, and then again two days later, thinking always of A, and this was pleasurable." Although he is a professional man of superior intelligence he continued, "It was probably a coincidence that my condition approved [a-p-p-r-o-v-e-d] at the same time I first masterbated [m-a-s-t-e-r-b-a-t-e-d], or was it?" (Masturbation was spelled correctly in other parts of the letter.)



These two "slips of the pen" betrayed the inner conflict which in fact had arisen during his psychotherapeutic treatment but was never adequately analyzed. Whenever he discussed masturbation he sought the writer's approval in various ways. He spoke of its frequency in the general population, rationalized such activity as safer than going to a prostitute and persisted in trying to get the writer to tell him it was permissible. When this approbation was not forthcoming he interpreted silence on the issue as a tacit approval since the writer had not specifically interdicted masturbation. At least that was the way he was going to take it.

The unsuccessfully repressed conflict, expressed itself again in a renewed demand for approbation accompanied by "medical proof" of its importance for his health. It is as though he were insisting, "Masturbation is desirable—it cured my colitis." In the face of such dramatic relief from bowel symptoms coincident with the return to genital masturbation, his indirect plea for approval could not go unanswered.

He continued to improve rapidly, gaining weight from a low point of 75 pounds to 156 pounds. The tuberculous infection is quiescent, and the colitis symptoms have cleared up. In view of the persistence of neurotic difficulties, he intends to resume psychotherapy.

This patient, like the first one described, demonstrates how a new orifice may be utilized for erotic gratification. The outlet represented a more acceptable area than the genitals for libidinal investment and provided a channel for the previously dammed-up sexual drives. The recurrence of prolonged physiologic disturbances in bowel functioning, precipitated by the withdrawal of codeine, strongly suggests the persistence of anal-erotic fixations from childhood. The functional disturbance was so invested with libidinal values that, even though codeine was given again, the pattern persisted until adequate erotic gratification could be derived from another source, that is the genital area.

It is beyond the purpose of this communication to discuss the etiology of ulcerative colitis and its relationship to character formation, compulsive symptomatology and the way in which specific life situations are managed. However, preliminary experience indicates that patients who have had artificial bowel openings for other reasons—such as carcinoma—do not ordinarily show the same type of erotic interest in their orifices.



The significance of libido theory for a better comprehension of psychosomatic disorders can no longer be overlooked. Repressed or conscious fantasies of organ functioning do, in actuality, lead to expression in distortions of the natural biological processes normally ascribed to such organs. Chronic alterations in function may then predispose toward the development of irreversible structural damage.

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## CARBON DIOXIDE THERAPY

BY GEORGE A. SILVER, M. D.

This is a report of the first 100 patients who received carbon dioxide-oxygen therapy at Duke Hospital, January to November, 1951. The inhalant mixture consisted of 30 per cent carbon dioxide and 70 per cent oxygen.

This type of treatment was inaugurated by Meduna<sup>1</sup> for psychoneurotic patients in 1943. His results showed an over-all improvement rate of 68 per cent, and justified continued use and exploration of the method.

The preliminary report<sup>2</sup> based on the first 30 patients treated at Duke University Hospital\* showed an improvement rate of 86 per cent. It was stated in that report that some relapses might be expected, and after six months the improvement rate in these original 30 cases dropped to 76 per cent. One case of alcoholism relapsed completely after two months; a depression was unmasked in another patient, necessitating electric shock at a later date; and a "chronic invalid" did not maintain her improvement more than a few weeks after treatment was discontinued. With these exceptions, the remaining patients reported as improved, have maintained the improvement or have continued to improve further.

This present report deals with an additional 70 patients combined with the original 30. The over-all picture showed no improvement in 25 per cent, slight but definite improvement in 27 per cent, marked improvement in 26 per cent and apparent recovery in 22 per cent.

A rather arbitrary classification of psychoneurotic conditions was used, as shown in Table 1.

This classification was used in a descriptive sense to give an idea of the main clinical picture presented by these cases.

Table 2 shows the number of treatments, the time during which these treatments were given, and the improvement shown, divided into columns: No Improvement (O), Slight Improvement (S.I.), Marked Improvement (M.I.), and apparently Well (W). The clinical picture is represented by the initials of diagnoses in Table 1.

This table would seem to indicate that there is little relationship between improvement and the number of treatments given. As

\*Durham, N. C.



Table 1

	No improve- ment	Slight but def. improvement	Marked improvement	Well	Total
Anxiety .....	6	6	7	4	23
Hysteria .....	0	0	2	2	4
Depression .....	5	2	2	6	15
Depression in an anxious person	3	3	4	5	15
Depression in a hysterical person	2	2	3	2	9
Psychasthenia .....	0	2	0	0	2
Neurasthenia .....	2	2	3	1	8
Alcoholism .....	2	1	2	1	6
Stuttering .....	1	5	0	0	6
Miscellaneous .....	4	4	3	1	12
Total .....	25	27	26	22	100

will be noted, a high percentage of the patients treated with 10 or fewer treatments, showed marked improvement, and patients having two or three times as many treatments showed lower percentages of improvement. This is in part explicable because cases not showing improvement with a small number of treatments were continued for a larger number. This longer-continued treatment is apparently justified as shown by the fact that three of eight patients showed marked improvement after more than 50 treatments. The writer feels that a much wider experience will be required before one can accurately determine the kind of case to be treated and the number of treatments required to effect improvement.

Table 2

Number of treat- ments	Clinical picture*										Treatment given during				Improvement			
											1	2	3	4+				
	A.	H.	D.	DA	DH	P.	N.	A.	S.	M.	Mo.	Mo.	Mo.	Mo.	O	S.I.	M.I.	W
0-10	1	1	1	1	2	0	1	0	0	3	10	0	0	0	0	4	3	3
11-20	4	2	7	3	5	0	3	4	2	5	32	3	0	0	11	6	10	8
21-30	10	1	5	8	2	1	2	2	1	2	20	9	3	2	12	11	4	7
31-50	5	0	1	3	0	0	0	0	2	2	1	4	6	2	1	2	7	3
51+	3	0	1	0	0	1	2	0	1	0	0	1	2	5	1	4	2	1
	23	4	15	15	9	2	8	6	6	12	63	17	11	9	25	27	26	22

\*See Table 1 for diagnostic classification.



There was very little selection of cases for treatment except that, (1) symptoms of depression were not severe enough to necessitate electric shock therapy, (2) no major psychoses were treated, and (3) in general, the so-called psychoneurotic reactions constituted the largest group of cases. They represent the entire first 100 patients treated. With four exceptions, all received at least 10 treatments. In an effort to judge the value of this therapy, some cases believed unsuitable had a trial, at times with surprising results. Two patients who responded well to carbon dioxide-oxygen had had prior classical psychoanalysis without benefit. Some had previous, somewhat prolonged, non-analytic therapy in one form or another. Some—incapacitated for many years and the recipients of considerable and extensive medical attention through those years—were able to make adjustments again and function at a more adequate level.

Under the miscellaneous group are a variety of patients not easy of definite classification, as used here. These cases are summarized briefly.

One woman, whose chief complaint was sexual frigidity, was considered well by both the husband and the patient herself after 10 treatments. One case of back pain, another of side pain, both elusive of diagnosis, were not benefited by the carbon dioxide-oxygen therapy. Two other patients, one with torticollis, the other with writer's cramp, were not improved. A woman who showed some intellectual changes and marked emotional lability, with uncontrollable anger spells, following a cervical operation, was markedly improved to the point that her husband removed her from the hospital against advice after seven treatments; she later wrote for information in order to get the treatments closer to their home.

A 72-year-old man who had difficulty in breathing had no relief from his complaint, but was less disturbed about it and felt stronger, brighter, and in better spirits. A 55-year-old woman, formerly alcoholic, was lobotomized for intractable pain of thalamic origin. Following lobotomy she was relieved of pain and morphine addiction. She became, however, complaining, querulous and reverted to alcoholism. With carbon dioxide-oxygen therapy, she showed objective, but no subjective, improvement. Later she asked to have further treatment and recognized the improvement herself. A patient with a paranoid schizophrenic-like reaction had the main complaint of inability to remember details. His memory



after 16 treatments, improved, and was recovered after 25 treatments. He, also, noticed many other signs of improvement: The most notable was a lessened tension about his homosexuality, and he requested continuation of therapy.

A senile, depressed, physician, with paranoid ideas and "solar plexus trouble" was completely relieved from the epigastric difficulty, had partial relief from the depression and developed insight into his delusional system, but was unable to modify it. A woman of 43, an invalid with multiple sclerosis of 10 years duration with stationary symptoms in the previous three years, had 25 treatments. Except for equivocal changes toward emotional stability, the only definite thing she could report was her ability to do fine and precise motions with her hands again—such as fine sewing. The twelfth patient was a boy of 11, who had *maladie de tic*. In spite of careful medical attention over the previous three years, he had progressed to the point where he had no conscious control over his shoulder and head jerks, guttural sounds and foul utterances. After 15 treatments, with no other medication used, he was a changed boy. He still has occasional twitches and throat noises when under tension but is a happy, active boy, diligent in home chores and interested in school work.

It is assumed that an individual who comes for treatment is primarily interested in his own well-being. For that reason, his own appreciation and appraisal of his symptomatology has received considerable weight in the evaluation of the results of this form of treatment. The final evaluation of his improvement was the joint opinion of the patient, relatives and the physician's own appraisal. In no case is improvement reported on the therapist's opinion alone. Unless the patient and the family reported definite improvement, it is reported as no improvement. At times, "apparent cure" has been reported as only marked improvement because of the opinion of the therapist. A young man of 34, a psychopathic individual, was hospitalized as an alcoholic primarily because both his father, who was seriously ill, and his mother, a "nervous wreck," could no longer cope with him. He had carbon dioxide-oxygen treatment against his will but co-operated well in every other way. The treatments were discontinued after he had 13. He stated that he was no better and it is so recorded in the table, although it was obvious to medical and ward personnel that he was less "jittery" and restless and had a good sleep pattern. Since he



had never been able to handle responsibility of any kind, it was with considerable surprise that the therapist learned some four months after he left the hospital, that he had been managing his father's business, had not been drinking and to all intents and purposes seemed to be a changed man. As mentioned before, since there were in this case so many equivocal circumstances, it is reported as no improvement in respect to carbon dioxide-oxygen therapy.

Patients listed as showing slight but definite improvement are illustrated by a 36-year-old woman with torticollis who had relief of pain, relaxation of severe spasm and the ability to feed herself for the first time in four months. This woman, partly for financial reasons, but mostly because she was "homesick," decided to return to Florida without sufficient treatment. A 46-year-old, rigid, compulsive woman, treated for spastic colitis, is reported as "slight but definite" improvement. She came a considerable distance to receive 30 treatments but now is able to continue treatment with a doctor in her home town; and, at last report, her colitis was improved and she was less tense and was relieved of indecision. Another patient, a "chronic invalid" for 13 years, became less vociferous in her complaints, developed a good sleep pattern, was relieved of constipation and was more effective about her home.

Marked improvement is illustrated by a neurasthenic who considered himself well after 20 treatments and returned home. He was believed inadequately treated and this proved to be the case. In a letter received three months later, he asked for information about receiving the treatments closer to his home. A very anxious young woman had many phobias and panic reactions and was subject to sleep-walking. After 25 treatments, she was sleeping quietly and restfully, was able to go wherever she wanted and was picking up her social activities after a lapse of two years. More treatment was suggested but did not seem practical to the patient at that time. Another patient, a young man, was incapacitated by vague sharp pains around the region of his heart. These attacks of pain disappeared, and the patient returned to work by the twenty-eighth treatment. Four months later, he reported himself completely well, but had some doubts about cardiac disease.

Perhaps the most dramatic "cure" was the 28-year-old woman, incapacitated for three months, sleepless, restless, with marked loss of weight and marked emotional lability, who, after nine treat-



ments, was reported by her husband as, "If it wasn't for the kids, we'd be on our honeymoon." Another woman of 45 who had had three recurrent depressions for which she had received electric shock therapy was started on carbon dioxide-oxygen treatments in her third depression, after failure to recover with electric shock. She felt well after 12 treatments, and the course of treatment was continued to 25. After this first series of treatments, the patient relapsed and carbon dioxide-oxygen therapy was again started. A second course of 35 treatments was followed by relief of all symptoms, and three months later she is still well. An alcoholic young man, the despair of his family, has been well, happy, and productive for six months—the longest period of abstinence in 12 years.

In the administration of the treatment, the policy has been to tell the patient that little can be expected in the first 10 treatments. Improvement is apt to begin between the tenth and twentieth treatment. If improvement occurs earlier, it is likely to be evanescent. If the patient begins treatment, he should be continued for about 30 treatments and if, then, no improvement has occurred, it is unlikely that any will. The treatment should then be abandoned. If there has been some improvement by the twentieth to thirtieth treatment, therapy can be given indefinitely—as long as improvement continues.

The treatments are easy to administer. A tank of the gas mixture made commercially costs about \$10 and is sufficient for about 100 treatments. A two-stage regulator allowing free flow of the gas mixture and a mask with a large (five-liter) re-breathing bag are the only other equipment required. The regulator in current use has a line gauge calibrated to deliver up to 60 pounds of the gas mixture per square inch. The treatments are short, the total time varying from five to 10 minutes unless combined with psychotherapy, which is not necessary in the average case. The writer believes the contraindications to the treatment are severe cardiac or pulmonary disorders and excessively high blood pressure.<sup>3</sup> Some caution should be exercised, in the administration of the gas, not to increase the distress of the depressed or anxious patient. The same might be said of the aggressive patient who is likely to have a violent motor reaction early in the course of treatment. The number of inhalations varies with the patient, from 20 to 40 on the average, although 70 and even 90 have been used at one treatment without ill effect.



Some patients have difficulty in taking the treatment because of a feeling of "choking," "strangulation" or, "I can't get my breath." In the writer's experience, this occurred severely in one out of six patients. In his previous earlier experience, treatment had to be abandoned in these cases, and these are not included in this report. Fortunately, on the suggestion of Meduna, this difficulty has been circumvented. Undiluted nitrous oxide was hooked into the system. This gas is administered first for rapid safe anesthesia; and, as signs of anoxia develop (eight to 10 inhalations), the carbon dioxide mixture is turned on. The patient is unaware of this change and usually has no trouble taking the treatment in this manner.

#### CONCLUSIONS

One hundred patients received carbon dioxide-oxygen therapy. There was no improvement in 25 per cent, slight but definite improvement in 27 per cent, marked improvement in 26 per cent and apparent recovery in 22 per cent, over the one to nine months following therapy covered by this report.

Carbon dioxide-oxygen inhalations are easy to administer, are safe and inexpensive, and in the present series of cases, were effective in producing some degree of improvement in 75 per cent of the patients treated.

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# DURATION OF HOSPITALIZATION, READMISSION RATE AND STABILITY OF DIAGNOSES IN VETERANS HOSPITALIZED WITH NEUROPSYCHIATRIC DIAGNOSES\* †

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The group of persons who compose this study were a 30 per cent random sample of all patients admitted to Veterans Administration hospitals during April 1948, who were diagnosed as having disorders of a psychiatric or neurological character. Each of them was traced from the date of his April 1948 admission through April 1950. The discharges, readmissions and diagnostic appraisals on each hospitalization were incorporated in the record.

Some of the limitations of the record should be pointed out. The nature and extent of hospital care of these persons previous to April 1948 is unknown. The first admission in this study may not by any means be the first admission of the patient for his current illness. The patients first appear in the record as a group of approximately contemporary admissions to VA hospitals. They are veterans, and, on this appearance, they were admitted for treatment or observation with psychiatric or neurological diagnoses.

The number of admissions and the reported diagnoses are represented with assurance that there were at least these admissions and diagnoses for each veteran reported. There is no such assurance that the search of records disclosed every hospitalization in a VA hospital. A few may have been missed. Nor is there any reflection in this material of hospital care in other public or private hospitals. As a consequence it must be assumed that there were some hospitalizations of these veterans concerning which the writers have no available records, and that the representations of this study are, therefore, not fully comprehensive.

The unusual characteristic of this material is that it follows the individual patient through repeated hospitalizations, even when they occur in different hospitals. His illness episodes are bridged over interhospital transfers and over other administrative actions within the VA system that are necessarily reported by individual

\*Presented at the annual meeting of the American Psychiatric Association in Cleveland, May 1951.

†From the Veterans Administration Central Office, Washington, D. C.



hospitals as terminations of treatment. As a result, more accurate measures of illness duration and of readmission rates are made available.

The 30 per cent sample of April 1948 admissions totalled 1,621 individual veterans. In such stable characteristics as "Wars of Service" and "Service Connection" the composition of the sample is proportionately similar to routinely reported discharges and admissions.

Table 1 gives the distribution of admission diagnoses of these patients. Figure 1 indicates the percentage of the total number and the percentage of those in each diagnostic group continuously

Table 1. Admission Study Group (Unduplicated Persons)

Diagnostic class		Number
All diagnoses		1,621
Psychoses of unknown etiology	360	
Schizophrenia		303
Affective		36
Other		21
Psychoses of organic or demonstrable etiology	125	
Alcoholic		54
Senile, presenile, and arteriosclerotic		26
Other		45
Psychoneuroses	534	
Anxiety reactions		265
Hysterical reactions		96
Somatization reactions		82
Depressive reactions		26
Other		65
Character and behavior disorders	282	
Alcoholic addiction		144
Pathological, psychopathic and immat. pers.		113
Other		25
Neurological disorders	245	
Vascular		77
Trauma		41
Inflammatory		30
Other		97
Observation (mental)	75	

remaining in the hospital (solid line) or present in the hospital (dotted line) for the 25-month period. The dotted line indicates those readmitted as well as those remaining continuously.

Perhaps the most conspicuous and encouraging finding of the study is the high discharge rate of hospitalized veteran patients.



## CONTINUED AND RECURRING HOSPITAL CARE OF APRIL 1948 ADMISSIONS

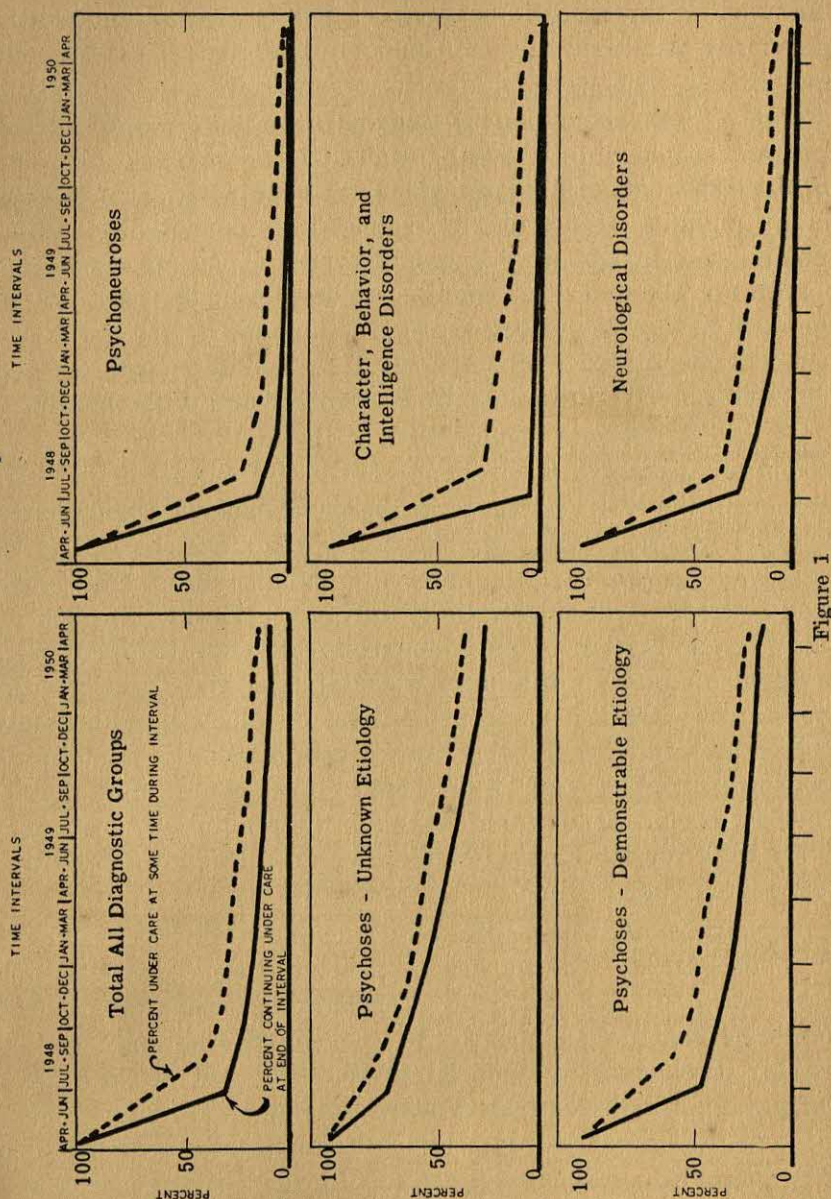


Figure 1

The least favorable discharge rate is with the psychoses of unknown etiology—predominantly schizophrenia. However, even there, only 27 per cent of the total group have had an uninterrupted hospitalization of 25 months, and only 36 per cent are in a veterans' hospital at the end of 25 months. From the psychoses of



known etiology, which in the writers' group are predominantly alcoholic, 13 per cent were continuously hospitalized for 25 months and 21 per cent were in a veterans' hospital at the end of 25 months. Next come the neurological disorders, with 5 per cent continuously hospitalized for the period and 11 per cent in a hospital at the end of the period. Of patients with character, behavior and intelligence disorders, only 1 per cent were hospitalized continuously for 25 months, and only 6 per cent were in a veterans' hospital at the end of 25 months. The psychoneuroses presented the most favorable outlook as regards hospitalization with only 0.4 per cent hospitalized continuously for 25 months and less than 4 per cent under veteran hospital care at the end of 25 months.

While the patients hospitalized at the end of 25 months in the psychotic group were preponderantly individuals who had remained in the hospital, those in the psychoneurotic and character disorder groups were preponderantly readmissions. It is noteworthy, however, that the rates of readmission of both of these groups dropped off substantially during the 25-month period. The rate of readmission of psychoneurotic patients dropped from 11 per cent of those on discharge status in the first three months of the study to about 5 per cent of those on discharge status at the end of the study, while the rate of readmission in the character disorders dropped from 24 per cent to 6 per cent in a like interval. The fact is conspicuous that although the readmission rate is relatively high for the character disorder group, it drops off rapidly with the passage of time.

Discharges against medical advice constitute 9.6 per cent of the total discharges. Discharges because of absence without official leave constitute 3.8 per cent. Discharges because of disorderly conduct constitute 0.9 per cent. These, together, are called irregular discharges and constitute 14.3 per cent of the total discharges. They are lowest for the patients with diagnoses of organic neurological disorders (8.4 per cent) and of psychoneuroses (8.8 per cent). Psychoses of organic or demonstrable etiology occupy an intermediary position (11.5 per cent). The ratios are high for the character and behavior disorders (16.4 per cent) and for the psychoses of unknown etiology (20.2 per cent), and highest of all for the small category, mental observation (49.6 per cent). This last may be partly an artefact in that some of the patients in this group may be so listed because they went out against advice with-



out remaining in the hospital long enough for the establishment of a diagnosis.

If one compares the percentage of individuals who, if they sought further hospitalization, always returned to the same hospital, with those who sought different hospitals there is an interesting parallelism to the rate of irregular discharge. This is revealed in Table 2. This table provides an index of the patient's confidence in the hospital. The following generalizations are suggested:

Table 2. Indices of Patient Morale

	Percentage of dis- charges irregular	Percentage of rehos- pitalized patients going to another hospital	Percentage of hospital readmis- sions to another hospital
Neurological disorders .....	8.4	25.6	20.1
Psychoneuroses .....	8.8	39.1	45.5
Psychoses of organic or demonstrable etiology	11.5	42.9	43.0
Character and behavior disorders .....	16.4	58.8	59.0
Psychoses of unknown etiology .....	20.2	55.1	61.5
Mental observation .....	48.7	70.6	65.8

1. Patient morale in these terms appears to be higher for those diagnoses in which the personality is well-preserved than for those diagnoses involving personality disintegration.

2. Patient morale appears to be higher for organic diagnoses than for non-organic diagnoses.

3. Patient morale appears to be higher for diagnoses of known etiology than for diagnoses of unknown etiology.

4. Patient morale appears to be higher for definite diagnoses than for indefinite diagnoses.

If one considers the stability of diagnosis on readmission in relation to the various diagnostic groups, the results are interesting. Table 3 compares the stability of diagnosis on next admission for three groups of psychiatric diagnoses on previous admission—schizophrenia, character and behavior disorders, and psychoneuroses. The stability of diagnosis is greatest with schizophrenia and least with the psychoneuroses.



Table 3. Relation of Admitting and Readmitting Diagnoses

Readmitting diagnoses	Schizo- phrenia (116 cases) Percent- age	Psycho- neurosis (237 cases) Percent- age	Character and be- havior disorders (234 cases) Percent- age
Diagnoses other than neuropsychiatric..	4.3	37.5	28.6
Neurological disorders .....	0.0	2.5	4.7
Mental observation and ill-defined men- tal morbidity .....	5.2	3.4	3.8
Psychoneuroses .....	6.0	19.4	8.1
		15.6	
Character and behavior disorders .....	6.9	12.7	32.5
			12.0
Psychoses ... { Schizophrenia, same type	53.4	8.9	10.2
{ Schizophrenia, other type	17.2		
{ Other psychoses	6.9		

It should not be assumed that all changes are due to confusion in diagnoses. Only the principal diagnoses are compared here. No psychiatric diagnosis is a protection against acute appendicitis, for example, and if an ambulatory schizophrenic or a psychoneurotic is hospitalized for appendectomy he will be classified under a surgical primary diagnosis regardless of the persistence of his psychiatric condition and its recognition in a secondary diagnosis. Furthermore, a nonpsychiatric diagnosis may in fact be intimately related to a psychiatric one. If an alcoholic patient stumbles in front of a truck and comes back into the hospital with traumatic injuries, the incident may be a result of his addiction to alcohol. A gastric neurosis may result in organic changes in the gastrointestinal tract of sufficient clarity to justify an organic diagnosis on rehospitalization.

With these potentialities recognized, the fact remains that the psychoneuroses in particular have a conspicuous instability of diagnosis on rehospitalization and the character and behavior disorders are relatively unstable.

The writers have further examined the specific shifts of diagnosis on rehospitalization among 10 diagnostic categories. Some



consolidation of categories was necessary in order to have sufficient material to determine stability statistically. They selected the following categories:

1. Paranoid schizophrenia.
2. Schizophrenia other than paranoid.
3. Alcoholic psychosis.
4. Anxiety reaction without or with hysteria or somatization.
5. Hysterical reaction without anxiety.
6. Somatization reactions.
7. Other psychoneuroses (preponderantly hypochondriacal or depressive). This group will hereafter be called miscellaneous psychoneuroses.
8. A group of personality disorders made up of inadequate personality (49 diagnoses), emotionally unstable personality (31 diagnoses), dependency reaction (19 diagnoses), antisocial personality (17 diagnoses), and immaturity (1 diagnosis).
9. Alcoholic addiction.
10. Ill-defined mental morbidity.

These groupings were made on the basis of: (1) diagnostic similarity, and (2) the absence of evident dissimilarities in the patterns of diagnostic groupings to which they shifted on rehospitization.

Having selected these 10 diagnostic classes, one can compare the frequency with which there are shifts from one to another on rehospitization.

For example, the shift between the diagnosis of schizophrenia, paranoid type, and the diagnosis of alcoholic psychosis is revealed in Table 4. This table compares the diagnosis of paranoid schizophrenia and of alcoholic psychosis on prior and subsequent hospitalizations. There are 89 such comparisons of prior and subsequent admissions. In 45 instances the diagnosis on both hospitalizations was paranoid schizophrenia. In 39 the diagnosis was alcoholic psychosis on both hospitalizations. There were three instances in which on the prior hospitalization the diagnosis was paranoid schizophrenia and on the subsequent hospitalization it was alcoholic psychosis, and there were two instances in which



Table 4

Diagnosis on subsequent admission	Diagnosis on prior admission	
	Alcoholic psychosis	Paranoid schizophrenia
Paranoid schizophrenia .....	2	45
Alcoholic psychosis .....	39	3
		$r = +.98$
		$k = +.19$

the diagnosis on prior admission was alcoholic psychosis and on the subsequent admission was paranoid schizophrenia.

With this material, one can calculate the correlation between the diagnosis on prior hospitalization and the diagnosis on subsequent hospitalization. The writers used the tetrachoric correlation coefficient—in this case  $+ .98$ . This represents a high degree of correspondence between the first diagnosis and the second diagnosis when the diagnosis of paranoid schizophrenia is compared with that of alcoholic psychosis. These diagnoses remain distinct and discrete on subsequent admissions, with little change or confusion. This high degree of consistency in diagnosis may be taken to indicate that these diagnostic categories are both well-defined and significantly different. If, on the other hand, one considers the stability of the diagnosis of psychoneurosis, anxiety reaction, as compared with the group of inadequate, emotionally unstable personality diagnoses, it is found that in 33 instances a patient was diagnosed anxiety reaction on both his prior and his subsequent hospitalizations, and in 44 instances he was diagnosed as falling in the inadequate, emotionally unstable personality group on both his prior and his subsequent hospitalizations (Table 5). Thus in a total of 77 cases the prior diagnosis was confirmed by the subse-

Table 5

Diagnosis on subsequent admission	Diagnosis on prior admissions	
	Anxiety reaction	Inadequate, emotionally unstable personality group
Inadequate, emotionally unstable personality group .....	25	44
Anxiety reaction .....	33	20
		$r = +.40$
		$k = +.92$



quent diagnosis. There were, however, 25 instances in which the prior diagnosis was anxiety reaction and the subsequent diagnosis fell in the inadequate emotionally unstable personality group, and 20 instances in which the prior diagnosis fell in this group, and the subsequent diagnosis was anxiety neurosis, making a total of 45 instances in which the diagnosis changed from one group to the other. In this instance the correlation between diagnosis on prior and subsequent hospitalization was only  $+0.40$ . This would indicate that the categories themselves are either not fundamentally separated, or else that their definition is not sufficiently good to establish an effective separation in their actual application. A correlation between first and second diagnosis of  $+1.00$  would indicate a perfectly consistent diagnostic separation. A correlation of zero would indicate that purely random factors would account for such repetitions as appear. The range of correlations actually observed is from  $+1.00$  down to  $+0.40$ . To make an analysis of the interrelations of diagnoses, it is necessary to have an index of the resemblance between the different diagnostic categories. This was obtained from the correlation between successive diagnoses. For this purpose, the writers used  $k$ , the coefficient of alienation, defined statistically as  $\sqrt{1 - r^2}$ . A relation of purely chance consistency between prior and subsequent diagnosis would result in a  $k$  of  $+1.00$  and a relation of perfect consistency would result in a  $k$  of 0.

The correlation coefficient of  $+0.98$  between successive diagnoses when alcoholic psychosis is related to paranoid schizophrenia is transformed into a coefficient of alienation of  $+0.19$ , expressive of the resemblance of the diagnosis of alcoholic psychosis to the diagnosis of paranoid schizophrenia. The correlation coefficient between successive diagnoses of  $+0.40$  when anxiety reaction is compared with paranoid schizophrenia is transformed into an alienation coefficient of  $+0.92$ , expressive of the resemblance in practice of the diagnosis anxiety reaction to the diagnoses in the inadequate, emotionally unstable personality group. This procedure made it possible to prepare a matrix of the intercorrelations of the 10 selected or grouped diagnoses which was subjected to factor analysis. The range of values of  $k$  in this table, which forms the correlation matrix, is from 0 to  $+0.92$ , the latter factor reflecting a close similarity between the diagnoses of anxiety reaction and inadequate personality.



Factor analysis is a statistical process for determining the minimum number of independent factors which will make it possible to account for a table of intercorrelations. This table was subjected to a factor analysis by the centroid method and three factors were extracted. The centroid factors were then subjected to a process of rotation in order to arrive at a psychologically meaningful solution. In the solution arrived at, the three factors are, in geometrical terms, very slightly oblique, or, in statistical terms, are very slightly correlated, one with another. The factor loadings are listed in Table 6.

Table 6. Factor Analysis of Repeated Admission Diagnoses—Rotated Factor Matrix

Diagnosis	X	Y	Z	k <sup>2</sup>
Schizophrenia, other than paranoid .....	.68	.01	.11	.51
Paranoid schizophrenia .....	.59	-.03	.11	.37
Miscellaneous psychoneuroses .....	.06	.80	.04	.75
Psychoneurosis, somatization reactions .....	-.02	.70	.10	.55
Anxiety reaction .....	.03	.83	.43	.99
Inadequate, emotionally unstable personality .....	-.02	.60	.45	.63
Hysterical reaction .....	.14	.27	.04	.13
Alcoholic addiction .....	-.05	.49	.65	.72
Alcoholic psychosis .....	.14	.00	.46	.78
Ill-defined mental morbidity .....	.30	.62	.60	.63

Factors	Correlation between primary vectors		
Schizophrenic factor .....	X	.X	Y
Psychoneurotic factor .....	Y	.31	
Factor of alcohol poisoning .....	Z	-.11	.06

The factor most sharply defined is obviously schizophrenia. The only specific diagnoses with substantial loadings on this factor are *paranoid schizophrenia* (+.59) and *schizophrenia, other than paranoid* (+.68). A third entry which does not really constitute a diagnosis also has a loading on this axis (+.30). This is the ambiguous entry, *ill-defined mental morbidity*. It is significant that the loading of this category on the schizophrenic axis is only half its loading on the other two axes. This is another fact which indicates there is less confusion on the schizophrenic axis than on either of the others.

Falling along the second axis are *psychoneurosis, somatization reactions* (+.70), *miscellaneous psychoneuroses*, (+.80) and, at a



lower level, *hysterical reaction without anxiety* (+.27). This axis seems clearly defined as a psychoneurotic axis.

The only diagnosis falling close to the third axis is *alcoholic psychosis*. However, the diagnosis with the largest loading is *alcoholic addiction*. This seems to be an axis which may be called alcohol poisoning.

The last column of Table 6 contains the unrotated common factor variance. It is an indication of the fraction of the total variance of each item which is accountable in terms of the loadings with the three factors. It is notable that while this analysis accounts quite adequately for the changes in diagnosis of such diagnoses as anxiety reaction, alcoholic psychosis and miscellaneous psychoneuroses, only a small fraction of the elements determining the diagnosis of hysterical reaction appears to have been captured in this study and there would appear to be large elements in paranoid schizophrenia which are not reflected in the factors isolated.

If this analysis be accepted, then the diagnoses may be divided interestingly in terms of the contribution of these three fundamental factors. This is depicted in Figure 2, which is a representation by the method of extended vectors.

In this figure, the centers of the three circles represent the points at which the axes of the three factors pass through the plane of the figure. Those diagnoses falling within a circle are affected by that factor and are practically unaffected by the other two factors. Those falling on lines connecting two circles are affected by these two factors, and the one falling within the triangle is affected by all three factors.

Paranoid schizophrenia and other schizophrenia fall close to a schizophrenic center. Somatization reactions and miscellaneous psychoneuroses fall close to a psychoneurotic center. Alcoholic psychosis falls close to a center for alcohol poisoning. The variability of all these diagnoses indicates a substantial loading with one of the factors and an absence of the other two. There is a series of three diagnoses clustered along a line from the center for alcohol poisoning to the psychoneurotic center. These are diagnoses with significant loadings on two factors. All represent elements of both psychoneurotic tendency and alcohol poisoning. The relative importance of the psychoneurotic element progressively diminishes and the relative importance of the element of alcohol poisoning progressively increases as one moves from anx-



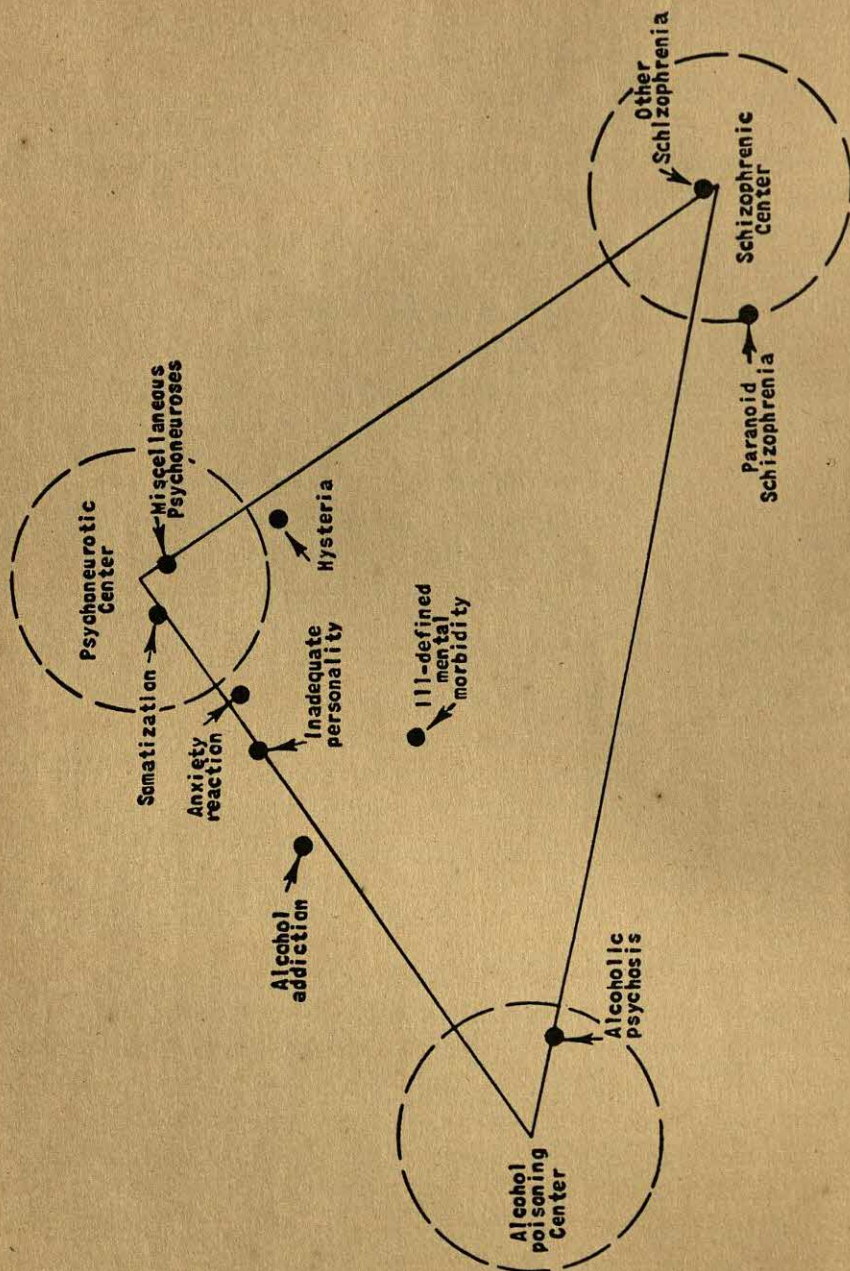


Figure 2

iety reaction to inadequate or emotionally unstable personality to alcoholic addiction.

It is of some interest that a count reveals that the shift from the diagnosis of alcoholic addiction to the diagnosis of inadequate,



emotionally immature personality occurs 48 times. The reverse shift occurs only 14 times. This suggests that the prominence of alcohol poisoning in these cases may recede at subsequent admissions over the two-year period, leaving a personality which is no longer diagnosed as alcoholic but which is diagnosed as inadequate or emotionally unstable.

The diagnosis of hysteria is outside the psychoneurotic center and has some leaning toward the schizophrenic factor.

The diagnosis of ill-defined mental morbidity is, as one might expect, well out in the middle of the triangle with substantial loadings on all factors.

#### SUMMARY

While the group of psychoses of unknown etiology, predominantly composed of schizophrenic patients, has the lowest discharge rate of any of the groups studied, nevertheless only 36 per cent of the original patients were in a VA hospital after two years, and only 27 per cent had remained there continuously for that period. In this category, patient morale, as indicated by irregular discharges and by the tendency to seek another hospital for readmission, is understandably poor.

The hospital stay of both psychoneurotic patients and patients with character and behavior disorders is, almost without exception, brief, but the tendency toward readmission is rather strong, particularly with patients classified as having personality and behavior disorders. However, in a two-year period the monthly rate of rehospitalization for those of the psychoneurotic group currently on discharge status declines from 11 per cent to 5 per cent and for the character and behavior disorder group declines from 25 per cent to 6 per cent. This would suggest a rather pronounced tendency toward stabilization over a period of time. The stability of diagnosis in the psychoneurotic and in the character and behavior disorder groups is at low level, and patient morale is not good in the latter group.

Factor analysis of the changes between 10 diagnoses or diagnostic groups of diagnoses indicates three underlying factors which account for such changes. These are a schizophrenic factor, a psychoneurotic factor and a factor of alcohol poisoning.

Paranoid schizophrenia and other forms of schizophrenia share, as one might expect, the schizophrenic factor. Somatization re-



actions and what the writers had called miscellaneous psychoneuroses (predominantly hypochondriacal and depressive reactions) appear to be rather "pure culture" psychoneurotic reactions, dependent on the psychoneurotic factor. The writers ascribe the alcoholic psychosis essentially to the factor of alcohol poisoning.

The conditions described as anxiety reaction, inadequate and emotionally unstable personality, and alcoholic addiction, as used in Veterans Administration hospitals, are closely related diagnoses, having two important factors in common, a factor of psychoneurotic tendency and a factor of alcohol poisoning. The significance of the psychoneurotic factor diminishes, and the significance of the factor of alcohol poisoning increases as one progresses from anxiety reaction to the inadequate and emotionally unstable personality group, to alcoholic addiction.

Hysteria appears to be the most individual and distinctive of the psychoneurotic reactions considered, and appears to have a little more in common with schizophrenia than do the somatization reactions, the anxiety reactions, or the miscellaneous psychoneuroses.

As a word of caution, the writers would say that factor analysis makes it possible to discover common factors running through several different diagnoses. The elements distinctive of a single diagnosis, do not, of course, come out as factors; and, for a common factor to be brought out, it must, in fact, be common to more than one diagnosis. An approach based on only 10 diagnoses obviously cannot be exhaustive. Such an analysis is limited by the number of diagnoses included. There is certainly reason to believe, for example, that there are important factors in psychopathic personalities other than a psychoneurotic factor and a factor of alcohol poisoning. To determine these additional factors one would need a series of related diagnoses which, in this study, the authors did not have in sufficient number.

Veterans Administration  
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## THE VALUE OF EARLY MEMORIES IN PSYCHOTHERAPY

BY RALPH J. KAHANA, M. D., I. HYMAN WEILAND, M. D.,  
BENSON SNYDER, M. D., AND MILTON ROSENBAUM, M. D.\*

In recent years there has been a good deal of interest in developing more efficient techniques of psychotherapy which are based on psychoanalytic concepts. Comprehensive planning of treatment in accordance with the needs of the patient has been considered an essential feature of such "brief psychoanalytic therapy."<sup>1</sup> To prepare a rational therapeutic plan the therapist must usually arrive at a meaningful psychodynamic formulation of the case at the beginning of treatment. One of the techniques that the writers have found useful in achieving early psychodynamic understanding is that of eliciting the earliest childhood memories of patients during the diagnostic period. Patients are asked directly for their earliest recollections during intake interviews, and in the exploratory phase of psychotherapy. In instances in which the patient gives only one memory, he is asked if there are any others; and further memories are usually elicited. In the dynamic understanding of these memories, attention is paid to the sequence and relationships of the memories as well as to the content. Any spontaneous comments (associations) on the memory are also noted and treated as part of the memory.

Early memories form a spectrum ranging from true and factual experiences to complete fantasy. Regardless of the validity of the content, the memories may help in understanding the dynamic structure of the personality. It must be stressed that early memories are of the greatest clinical usefulness when integrated in the total psychiatric anamnesis rather than treated as isolated phenomena. They often reflect the patient's principal unconscious conflicts, and may refer to emotionally traumatic childhood experiences, the patient's main ego defenses and at times to transference trends. When early memories are elicited during interviews with patients who are presented at graduate and undergraduate teaching seminars, they have provided valuable ready illustrations of psychodynamic patterns.

\*The writers wish to express appreciation to Dr. I. Arthur Mirsky, Dr. Henry D. Lederer, Dr. Stanley L. Block and other senior staff members and junior house officers of the department of psychiatry, University of Cincinnati, College of Medicine, and Cincinnati General Hospital, for helpful critical suggestions and access to case material.



Review of the psychiatric literature of the past 30 years reveals only a few studies of earliest recollections. Most of these stem from Freud's elucidation of the concept of screen memories.<sup>2</sup> Freud observed that some earliest childhood recollections were of indifferent events that could not have produced any strong emotional effect. This contrasted with most adult and childhood memories which are of emotionally significant experiences. He reported an investigation of such an emotionally indifferent recollection and demonstrated that it was actually a screen memory representing a compromised expression of repressed instinctual wishes. Freud suggested that "screening" occurs to some extent in all childhood recollections, and believed that the essential emotional experiences of childhood are preserved in screen memories.<sup>3</sup>

Rapaport<sup>4</sup> notes that the contribution of psychoanalysis to the theory of memory concerns forgetting or the non-emergence into consciousness through repression; the mechanisms encountered in the analysis of forgetting are the same that perform the dream work and these constitute specific memory functions. It might thus appear theoretically correct to analyze earliest memory in the same manner as dreams. However it must be recognized that the dream occurs in light sleep when ego control is weakened, whereas the earliest memory is produced by the awake individual in a setting of stronger ego control. It is possible therefore that different information is obtained from early memories than from dreams.

Several psychological investigations of the manifest content of earliest memories have been conducted in groups of "normal" adults and children.<sup>5, 6</sup> These studies reveal that the majority of earliest memories were of unpleasant experiences. Blonsky<sup>6</sup> cites Adler as having indicated that the earliest memory gives a picture of how the patient solves important life problems. Adler believed that the earliest memory provided a simple way of uncovering the feelings of inferiority which he held to be of basic importance. Stern<sup>7</sup> reported the usefulness of early memories in understanding the dynamics of children with psychiatric illnesses.

Schachtel<sup>8</sup> defines memory as a function of the living personality which can be understood only as a capacity for the organization and reconstruction of past experiences and impressions in the service of present needs, fears and interests. This definition emphasizes the close relationship between current personality functioning and the memory picture which an individual retains of



past experience. However, in stating that the present shapes our view of the past, the definition neglects the effect of past experience in determining present needs, fears and interests. Earliest memories are an organic part of the personality and, as such, reflect total personality functioning.

The following case abstracts illustrate various kinds of meaningful information found in early memories.

### *Case 1*

This is a verified screen memory demonstrating a childhood trauma.<sup>9</sup>

A 53-year-old, white, married man had suffered from attacks of anxiety and claustrophobia for 30 years. The first attack took place while the patient was on a business trip with an older man shortly after his marriage. The patient was shocked and frightened when the older man suggested that they pick up two girls. Subsequently attacks occurred in such specific settings as when he was in a berth on the train and when a barber placed a towel over his nose preparatory to shaving him. A recent attack occurred after a doctor had packed his nose with penicillin.

The patient was a successful and self-made business man with obvious pseudo-masculine character traits. He bragged of his prowess not only as an athlete but also as an engineer, despite lack of formal education. He had invented numerous gadgets and for some years had been engaged in working seriously on a perpetual motion machine.

Shortly after his marriage, sexual difficulties appeared. His wife was frigid and very inhibited sexually. He asserted that in 30 years there were only 10 or 15 marital sexual experiences. He considered himself to be "oversexed" and in the past 10 years had been living with an attractive younger woman with whom he enjoyed sex. He had kept up his home for social appearances, and his wife and sons knew and accepted this arrangement.

When the patient was asked of his first awareness of sex he told of masturbating at the age of four or five and engaging in sex play with many little girls. He vigorously denied any traumatic experiences associated with early sexual behavior. The therapist was immediately struck by the unusual clarity and lack of anxiety associated with this early sexual material and felt that the ease with which this material came out indicated that the patient had a



strong need to deny childhood sexual traumatic incidents and was utilizing the early sexual memories as a cover. An attempt was made to shorten the psychotherapy by the use of a sodium pentothal interview.

This interview was sterile until the very end, when the patient was asked to give his first memory. Prior to this time, he had insisted that there were no unpleasant memories and no fears during childhood. He then mentioned an accident, occurring at about the age of four or five, in which his nose had been broken. This recollection was followed by another, from the age of five or six, in which his father had slaughtered his pet pigeon, which he had had since he could remember. The bird was five or six years old when his father had killed it by cutting its throat in front of him. Later the family ate the bird. He denied that he was frightened by this experience, but cautiously admitted that he was a bit angry at his father. He then spoke of fear of birds, revealing that he could not handle a bird because he could not stand the warm, soft, wriggling body in his hand; and he admitted he still became extremely frightened if a bird happened to fly into his house. He mentioned how fond he had been of his pet pigeon and how he had loved to fondle it and do tricks with it. At this time it was noted that the patient's hands gradually shifted so that they covered his genitals, and he was allowed to wake up. When awakened, he expressed the desire to urinate.

The patient insisted that the memory was true despite the fact that collateral history from an older sister revealed that the pigeon had belonged to the father and had died a natural death. In the next interview, the patient recalled memories in which his father had threatened him for masturbating and sex play, and then remembered that his father had tied his hands to his bed at night to prevent masturbation.

*Comment.* The early memories of childhood sexual activity represented a denial of the underlying intense castration anxiety. The early memories obtained in the pentothal interview were screen memories for castration anxiety, as revealed in the memories, recovered later, concerning masturbation threats by the father. His attempts to master the anxiety associated with these childhood traumata not only led to his neurosis but also were a determining factor in the development of his pseudo-masculine character structure.



*Case 2*

Early memories of a 24-year-old, white, married woman suffering from Raynaud's disease indicated her principal emotional conflicts and some of her ego defenses.

1. She recalled being forced at five years of age to sit in kindergarten with her hands clasped together as a punishment for general classroom unruliness. She clenched her hands so tightly that her fingers turned white, and her woman teacher was alarmed.

2. In early childhood, her mother would not allow her to help in the kitchen, because she was "so clumsy" with her hands.

3. When she was five the patient and her younger sister were playing with a boy cousin. He suggested that they exhibit themselves to each other. The patient and her sister refused. He proceeded to exhibit himself and was spanked by the patient's mother and his own mother.

These memories depict a situation in which the patient is punished by a parent figure (the school teacher) for an occurrence in which she is minimally to blame (general unruliness in the class). She reacts by suppressing her hostility, further punishing herself by clenching her hands, and simultaneously punishing and gaining the attention of the teacher (alarming her). The patient then indicates that her mother depreciated her, would not allow her to compete as a woman (help out in the kitchen), and felt that she did not use her hands properly (suggestive of forbidden masturbatory play). She finally shows that she feared mother's punishment for sexual wishes associated with exhibitionism. The boy in the final recollection is depicted as being punished for forbidden sexual activity. In both the first and third memories, the patient displaces blame from herself to others.

The patient had had frequent attacks of Raynaud's disease, in which her fingers became blanched and severely painful, for four years. The background of the onset of this illness reflects her sexually-motivated, competitive hostility to mother figures, and her reactive fear and self-punishment. Shortly before her first attack, the patient felt extremely resentful because her mother-in-law "had invited herself along" on a visit to the patient's husband in an army camp, and the husband had been more attentive to his mother than to her. After her return home, she had revenge fantasies of having extramarital sexual relations and her first attack began when she had an opportunity to do this. This and other at-



tacks served the purpose of preventing sexual acting out, but allowed expression of hostility and self-punishment. The patient had self-depreciatory, masochistic behavior patterns, sexual frigidity and much concern about exhibiting herself in public. Her main defense was one of regression from meeting adult emotional problems to a childhood conflict involving masturbatory impulses and hostility to both parents.

### *Case 3*

An early memory of a 29-year-old man with conversion hysteria indicates the early patterning of his present behavior.

At the age of eight or nine, he wanted to play the violin and kept weeping to his parents for one. "When I got one, I quit playing after three lessons. I quit easily, I'm just not a fighter."

The patient sought treatment for episodic headaches and anxiety. These were readily seen to follow life situations that would be expected to evoke annoyance or anger. He was usually unable to express these affects, although aware of them. However, he was not aware of the linkage between his symptoms and unexpressed hostility. The early memory gives a hint that the patient tends to give up in the face of obstacles ("I quit . . . after three lessons") and clearly indicates his need to present himself as one who does not succeed. He further equates success with fighting (" . . . not a fighter"). For these reasons, he avoided aggressiveness and success, because of his fear of hurting others, being hurt, or both.

Since rhythmic motion, such as playing the violin, often symbolizes masturbation or other genital activity, one suspects that this patient's problems also relate to conflicts about genital sexuality. This was borne out in the course of therapy when he complained of impotence and premature ejaculations. A graphic validation of the foregoing interpretations, is presented in the following episode of the patient's current life. During the course of therapy he married. On the first night of the honeymoon, intercourse was successful despite difficulty in effecting entrance. Successful intercourse was attained on the next two occasions, but he became somewhat anxious on the third night when his wife pointed out the presence of some bleeding and pieces of the torn hymen. Following this, he was unable to maintain an erection beyond the stage of foreplay unless he placed himself in the supine position with his wife above.



In addition to these leads to the patient's conflict and his modes of meeting them, one can suspect certain transference manifestations. He said he was "not a fighter" and presented himself throughout the therapy as demeaned and unsuccessful even though he had built up a thriving business. He had been passively compliant and denied any hostility toward the therapist while expressing a great deal by innuendo.

#### *Case 4*

An early memory sequence indicates regression from the genital level of libido organization in a neurotic character.

A 32-year-old, married, white man came for treatment because of work inhibitions. In the course of therapy, it became clear that his dependency needs were a defense against anxiety connected with sexuality.

His two early memories were as follows: 1. He remembered having had a birthday party at the age of three, at which he ate ice cream and cake. 2. At the age of four, he got into a fight with a group of boys, was struck on the head and ran home to his mother bleeding from his scalp.

These two memories depict in reverse order regression to oral dependency resulting from fears of aggressive competitive masculinity. Conflicts centering around this area of his life were the core of his neurosis.

#### *Case 5*

Early memories of a middle-aged professional man suffering from a peptic ulcer illustrate oral fixation and intense sibling rivalry.

The early memories were: 1. The patient was told that as an infant he was removed from his mother's breast because the breasts dried up. He was placed on a bottle, began to lose weight and was dying when his aunt discovered that the rubber nipples on the bottles were stopped up. 2. He recalls that when he was six, his next youngest brother, who was five, died. 3. He and a younger brother were lost and the younger brother was crying. The patient comforted him. 4. At the age of nine while on a ship coming to this country from Europe he hurt another younger brother when he pushed him off a chair.

This patient was first seen during a stage of panic with paranoid features, at a time when his wife threatened to divorce him.



The patient was pathologically jealous of his wife, was extremely possessive of her, and was resentful of any interest that she showed in anyone besides himself. His ulcer symptoms had started 10 years previously, during a time in which he was separated from his wife for a month while she was on a vacation. When he joined her, he asserted that she rejected him for two young male cousins with whom she spent all her time sailing. During a long course of psychotherapy in which a strong dependent transference was established, the patient weathered a divorce from his wife, recovered from his ulcer symptoms and made a good all-around adjustment.

The patient's basic oral fixation, with its resulting frustration, and intense hostility toward his mother (which later revealed itself in paranoid-like attitudes toward his wife) was disclosed in his first early memory, in which he depicted himself as almost dying as a result of the mother's neglect. The second and fourth memories illustrate his hostility to younger siblings, and, in the third memory, he not only disguises hostility toward a younger sibling but disguises his own deep wish to be cared for by representing himself in a maternal role toward the hated younger sibling.

#### *Case 6*

An earliest memory of a 20-year-old, single, white woman with conversion hysteria indicated an important transference tendency.

During the fourth psychiatric interview, the patient was asked to tell her earliest memory of her father. She recalled that when she was seven years old she would provoke his anger by not wanting to go to school. She would cry and not want to get dressed. Her father would become so irritated and upset by her activity that he would be unable to eat breakfast and would have to leave for work without it.

During the first five months of psychotherapy, the patient blocked attempts to get an anamnesis by remaining evasive and unspontaneous. She frequently cancelled appointments, came in late, and, on one occasion, arrived with an attack of laryngitis that prevented her from speaking. More recently she has progressed to a teasing, provocative attitude in which she will say that she has



many things to tell the psychiatrist but cannot bring herself to do this. The positive elements of transference appeared in some disguised seductive behavior and, more clearly, when the patient learned that her therapist might have to leave for military service. She failed to keep the next three appointments, had an amnesia for an interpretation of what this loss of a supporting figure might mean to her, and then expressed the feeling that the therapist did not believe that her symptoms were real.

The therapist had to contend with initial counter-transference feelings of frustration, although they never quite reached the point where his breakfast was spoiled.

### SUMMARY

In recent years, it has been a routine practice in the psychiatric and psychosomatic clinics and wards of the Cincinnati General Hospital to ask patients directly for their earliest childhood memories. It has been the writers' experience that—when the memories are analyzed within a psychoanalytic conceptual framework—they may provide meaningful information about unconscious conflicts, significant traumatic experiences in childhood, defenses against anxiety and transference reactions. Although such data can be obtained in other ways, it is often promptly available in the earliest memories and thus helpful in the early formulation of a case. Case material illustrating the utility of the earliest memory is presented.

This communication is the initial report of a more extensive clinical study of earliest memories.

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## A PRELIMINARY STUDY ON THE USE OF FLAXEDIL\*

(Gallamine Triethiodide) (Tri-(diethylaminoethoxy) benzene triethyliodide)

BY J. F. NEANDER, M. D., AND S. P. ALEXANDER, M. D.

Twelve years have elapsed since electric convulsive therapy was introduced in this country at the Pennsylvania Hospital. At the present time, it is a widely used, accepted procedure and the prevention of complications in its application is of great importance.

In a preliminary study using "Flaxedil," a new muscle-relaxing agent in electric shock therapy, a series of 13 patients with varying disabilities was chosen. These patients would ordinarily have received curare (d-tubocurarine, the active alkaloid of curare).

The most frequent complication of electric convulsive therapy is a fracture in the skeletal system, caused primarily by sudden contraction of muscles and deficiency in bone structure, as well as by faulty technique in application. In epilepsy, the tonic phase is much longer than in artificially induced convulsions, and this may explain why fractures are less frequent in epileptics.

Various measures have been introduced to minimize fractures. Von Braunmuhl treated patients in the embryo-like position, with little significant result. Some observers doubt whether the position of the patient plays an important role. Other attempts to reduce fractures included the use of magnesium sulfate, quinine metachloride, sodium amytal, glucose, dilantin, bromides, and calcium. Electric convulsive therapy with glissando attachment should theoretically reduce fractures because of less sudden onset of the tonic stage, but the experience of the writers during the past two years of using the glissando, does not substantiate this theory.

In 1940, Bennett reported on the use of curare, which has, at this time, become the accepted method for the prevention of fractures in electric convulsive therapy. This drug has been extremely useful in treating patients with bony deformities, recent fractures and cardiac deficiencies. Curare blocks the transmission of impulses across the myoneural junction in voluntary muscles, thus inhibiting the intensity of muscular contraction. In electric con-

\*Read at the Upstate Interhospital Conference, Syracuse Psychopathic Hospital, Syracuse, N. Y., April 23, 1952.



vulsive therapy, the dosage is regulated so as not to paralyze all the muscles completely, but rather to decrease the strength of the contractions. Curare has been accepted as an excellent muscle-relaxing agent but, at the same time, many psychiatrists have reported unfavorable side effects and fatalities that are primarily due to the drug. In reviewing the earlier material of Rockland (N. Y.) State Hospital, there were two recorded fatalities in curare-treated, electric convulsive therapy patients. The side effects, which usually are not serious but rather unpleasant, were: (1) respiratory embarrassment, requiring oxygen as a routine procedure; (2) a feeling of being paralyzed, accompanied by anxiety and resentment on the part of the patient after treatment; and (3) thrombosis of veins, an important complication in patients with poor veins.

In an effort to find a suitable substitute with effective muscular relaxation but without these complications, the authors are now using a new substance, "Flaxedil (Gallamine triethiodide)," which was synthesized in France by Rhône-Poulenc-Spécia. Patients who were to receive flaxedil were given the routine pre-electric-convulsive-therapy work-up, including thorough physical examination, dorsal spine x-rays, EKG and any other elective tests. A test dose of 1 cc. of flaxedil was given intravenously, over a period of one minute, the cubital vein having been used routinely. The patients were told they were receiving a muscle-relaxing drug which would have a short period of action, following which they would receive a second injection to neutralize the first, after which they would be put to sleep. After a period of three to four minutes, during which pulse, respiration and subjective symptoms were noted, an injection of 1 cc. of prostigmin was given by hypodermic. On the second day, a dose of  $1\frac{1}{2}$  to  $2\frac{1}{2}$  ccs. of flaxedil was given. According to the investigators, the theoretical initial dose of flaxedil tends to be 1 mgm. per kilogram of body weight. The fatal dose is 5.5 mgm. per kilogram of body weight. One cubic centimeter of flaxedil contains 20 mgms.; therefore about 3 to 4 ccs. should be given to an average person—but in the experience of the writers, a reduced grand mal seizure was obtained from dosages of 1.5 to 2.5 ccs. of flaxedil. Flaxedil is injected at a uniform rate of 1 cc. a minute.

The procedure just outlined, with tests for relaxation, such as asking a patient to raise and lower his head, open and close his



fists, and raise his body from a supine to the sitting position, was followed. In general, good relaxation occurred between one and one-half and three minutes, beginning with the eyelids, the masticator muscles, the musculature of the upper and lower limbs, and the abdominal muscles. The hand grip became weakened, and inability to rise to the sitting position quickly followed. At this time, an injection of 1 cc. of prostigmin by hypo and an application of ECT were given. The ECT stimulus was given in the same manner as unmodified ECT. The grand mal convulsion was definitely reduced in intensity, and the patients breathed spontaneously after cessation of the clonic movements. Oxygen was available but was required only about six times in over 170 treatments. This was in marked contrast to the experience of the authors when curare was used. It was routine practice to use oxygen with curare, because of extreme cyanosis.

Each electric shock treatment with flaxedil requires from six to eight minutes, from the beginning of the injection until the patient is returned to the recovery room. The patient is able to sit up about 20 minutes after the treatment and is able to return to his ward about 30 minutes later. Of the 13 patients treated, in this series with flaxedil-modified ECT, nine were males, four females. The youngest was 32; the oldest, 55. For physical contraindications to unmodified ECT, see Table 1. As is seen from the table, two patients had fractures of the scapula; though this condition is described as rare, it has not been so rare in the writers' experience. The psychiatric diagnoses and results are given in Table 2.

Table 1. Physical Contraindications to Unmodified ECT of Patients Treated with ECT and Flaxedil

Spine fracture, fresh .....	2
Spine fracture, healed .....	5
Severe spine deformity .....	1
Jaw pathology .....	1
Scapula fracture, fresh .....	1
Scapula fracture, healed .....	1
Congenital dislocation of both hips .....	2

### *Complications*

There were no complaints of complete paralysis on the part of patients in this series. They did complain of weakness, together with some anxiety. This anxiety could usually be allayed, however, by reassurance and by the effectiveness of prostigmin dur-



Table 2. Results of Treatment with ECT and Flaxedil

Diagnosis	Much			Unimproved	Total
	Recovered	improved	Improved		
Manic-depressive, depressed...	1	1	..	..	2
D. P. P. ....	1	1	1	..	3
D. P. C. ....	..	1	..	1	2
D. P. M. ....	..	1	1	..	2
Involuntional paranoid .....	..	1	1	..	2
Involuntional melancholia ....	..	..	1	..	1
Involuntional, mixed .....	..	..	..	1	1
Total .....	2	5	4	2	13

ing the test dose. There were no falls in blood pressure after injection of flaxedil, and in a few instances a moderate rise in blood pressure was noted. Thrombosis of veins did not occur, and respiratory embarrassment following ECT occurred in only one case.

This cardiorespiratory collapse, which occurred in a 46-year-old, white man, has been the only serious complication encountered by the authors, to date. This patient, who had a history of a mitral valvular involvement, with myocardial damage as evidenced by the EKG, had suffered from rheumatic heart disease in childhood and had had a "heart attack," according to the family, two years before admission to the hospital. On admission, his mental condition was such that he required immediate ECT, which was given with a full realization of the risk involved. He received 10 electric convulsive therapy treatments, preceded in each case by 2 ccs. of flaxedil, with no difficulties aside from the occasional use of oxygen for a brief period after the convulsion. During the eleventh treatment, which was carried out in exactly the same manner as the preceding 10, the patient developed severe cardiorespiratory collapse, with cessation of breathing; rapid, thready pulse; and severe cyanosis. He received immediate supportive treatment, including oxygen, additional prostigmin, and coramine intravenously. EKG studies before and after this incident, showed no change. Further treatments were discontinued in this case, since the patient had shown much improvement in his mental condition, and it was felt that the case did not warrant further risk. It was felt by one of the writers (S. A.), who gave the treatment and observed the immediate reactions, that the cause was not the flaxedil alone, but rather a cardiac condition which had been present for many years. This was



felt to be the case, since in previous injections of flaxedil, there were no serious cardiorespiratory difficulties. The blood pressure variations, patients' behavior, type of convulsion, change in blood picture and pathology for which patients were treated, are best illustrated by the figures recorded before, during and after treatments (Table 3).

### CONCLUSIONS

From the foregoing, the authors conclude that the "curarizing" effect of flaxedil is identical qualitatively with that of d-tubocurarine. Both act to block the transmission of impulses across the myoneural junction. Flaxedil has no consistent effect on the central nervous system, upon pain thresholds or upon synaptic transmission in the spinal cord, and does not affect sympathetic ganglia. Flaxedil does not have any effect upon the parenchymatous tissues of the viscera, or impede liver metabolism or urinary excretion, and has no apparent effect upon the uterus, intestines or myocardium. Flaxedil does not diminish blood pressure, vascular tone or myocardial activity, and therefore does not produce rapid vascular collapse such as may be seen following d-tubocurarine. Flaxedil has no histamine-like action. The fatal dose of flaxedil for the rabbit is 500 times greater than the customary curarizing dose. Flaxedil produced no thrombosis, and accidental peravenous injection caused no irritation.

The authors feel that preliminary studies indicate that flaxedil is a very valuable aid in ECT and is a safe substitute for d-tubocurarine. They are continuing to use it as a substitute because of the lessened toxic and unpleasant side-effects, as compared with curare.

### SUMMARY

Thirteen patients receiving modified ECT for structural reasons, were given flaxedil to obtain reduced grand mal seizures. A dosage of 1.5 to 2.5 ccs. was found adequate to modify the convulsion; the therapeutic effect of ECT, using the technique outlined in this report, was not interfered with by flaxedil.

### ACKNOWLEDGMENT

The writers wish to express their appreciation and gratitude to Dr. A. M. Stanley, senior director, and to Dr. D. M. Carmichael,



Table 3. Individual Treatment Data

Patient	Age	Did patient complain of feelings of paralysis?	Pulse before and after injection, treatment	B/P before and after injection, treatment	Cyanosis	Type of convulsions	Blood picture	X-ray (pathology)	Headache
1. C. C.	33	No	100.120.110	150/100 160/110 160/100	No	Mild	Normal	No change	None
2. C. J. F.	29	No	92.108.110	118/62 112/58 115/60	No	Mild	Normal	No change	None
3. G. A. N.	23	No	90.100.105	120/70 115/65 115/60	No	Mild	Normal	No change	None
4. M. A. N.	55	No	88.100.105	115/75 120/70 125/80	No	Mild	Normal	No change	None
5. S. L.	47	No	90.100.100	125/75 130/80 130/85	No	Mild	Normal	No change	None
6. E. H. F.	47	No	108.124.120	140/80 145/80 140/80	No	Mild	Normal	No change	None
7. G. H.	46	Occ.	88.116.120	150/85 150/95 150/90	No	Mild	Normal	No change	None
8. C. C.	33	No	100.120.110	150/100 165/110 160/100	No	Mild	Normal	No change	Occ.
9. P. A.	41	No	96.116.116	125/80 120/80 130/80	No	Mild	Normal	No change	None
10. B.	35	Occ.	95.105.100	150/100 135/80 155/80	No	Mild	Normal	No change	None
11. O. S.	32	No	90.110.100	125/80 130/80 120/80	No	Mild	Normal	No change	None
12. H. W.	42	No	92.106.120	150/95 150/95 175/100	No	Mild	Normal	No change	None
13. B. J.	49	No	100.110.100	150/90 160/100 170/110	No	Mild	Normal	No change	Occ.

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associate director of Rockland State Hospital, for the encouragement and practical support they gave in this investigation.

Rockland State Hospital  
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## FAMILY SETTING AND THE SOCIAL ECOLOGY OF SCHIZOPHRENIA

BY DONALD L. GERARD, M. D., AND LESTER G. HOUSTON, M. S.

This paper reports the results of an investigation into the social ecology of male schizophrenics in Worcester, Mass. Prior studies<sup>1</sup> have substantiated the findings of Faris and Dunham's well-known study, *Mental Disorders in Urban Areas*.<sup>2</sup> These studies have shown that:

(a) There are striking differences in the characteristics of different areas of a city. Extreme "disorganization," in terms of poor housing, delinquency, vice, infant mortality, tuberculosis rates, etc., is most evident in the central areas of large cities, that is, in the central business district and the surrounding slum areas. This disorganization decreases in gradient fashion toward the more stable, well-organized, peripheral suburban areas. "This pattern is not planned or intended and to a certain extent resists control by planning."<sup>3</sup>

(b) The rates of first admissions diagnosed as schizophrenia to public mental hospitals are highest in the central areas of the city and diminish in gradient fashion toward the suburban areas.

(c) Thus, the rates of schizophrenia fit into the ecological structure of the city. This suggests that the distribution of schizophrenia rates "is a function of the city's growth and expansion, and more specifically of certain undetermined types of processes."<sup>4</sup>

The fact that, in general, the rates are higher in areas of the city which are plausibly worse to live in, has been interpreted to mean that schizophrenia is enhanced, precipitated or somehow significantly influenced by these conditions of living. A corollary of this point of view is expressed rather succinctly in the following quotation. "Community 8A, the Gold Coast on the Lake front is an area settled by large hotels, inhabited primarily by the wealthy. The lack of serious social problems in this area is reflected in the low rate of all types of psychoses."<sup>5</sup>

Faris has suggested that there is a greater tendency for people reared in slum areas to develop schizophrenia. He says,<sup>6</sup> "there is a tradition of toughness among juveniles in these areas which makes more difficult the assimilation of children with egocentric and infantile traits into play groups and normal social living. In the more stable residential neighborhoods or in the suburbs, there may be a greater availability of sympathetic playmates and a



higher degree of parental and neighborhood cooperation which eases the process of assimilation of the spoiled child into play groups with other children." However, there is no explicit evidence that the slum areas of the city present the relevant background factors for schizophrenia<sup>7,8</sup> to a greater degree than do the suburbs. It would be plausible to argue that egocentric and infantile traits are harder to maintain in the slums, and are particularly enhanced for the children of the well-to-do suburban families with restricted play groups, governesses, etc. If the statistics of rates were reversed, if maximal rates occurred in the suburbs and minimal rates in the slums, undoubtedly such a plausible explanation would be seriously proposed.

This discussion is intended to emphasize that the relationships between the hospitalization rates and the condition of social living in a given area have not been clarified. From the standpoint of understanding the pathogenesis of schizophrenia, it would be useful to understand the factors which are responsible for the rather well confirmed "typical ecological distribution" of the schizophrenia rates. The present investigation was oriented toward evaluating the role of two possible determinants of this pattern.

(a) The mode of living of the patient at the time of his overt disturbance which led to hospitalization—in terms of the family setting in which he was living at this time.

(b) Residential instability.

Correlative to this, a study of residence distribution was made to determine whether the typical ecological patterning of schizophrenia rates occurred in Worcester, Mass.

#### METHODS

The subjects for this study were 305 male schizophrenics who were admitted to Worcester (Mass.) State Hospital from a residence in Worcester between 1931 and 1950. These patients were living in Worcester at the time their symptomatologies became overt enough to precipitate hospitalization. All mentally ill patients from Worcester (with the exception of those sent to private hospitals) are sent for observation and/or commitment to Worcester State Hospital. The subjects for this study were culled from the central diagnostic files and the yearly admission diagnostic records. Nativity, age at admission, diagnosis, residence,



and family setting (see following) were obtained from the face sheet (the first sheet of the patients' clinical folder) and checked with material in the psychiatric and social case study records.

## DATA

### 1. *Mode of Social Living*

The patients were categorized in terms of the home settings in which they were living when they showed symptoms of sufficient severity to warrant hospitalization. The categories used were: (a) Parental—living in the setting of the parental home. (b) Marital—living in the setting of the patient's own marital family home. (c) Sibling—living with siblings. (d) Single—living alone, unmarried, out of any family setting. (e) Divorced—living alone, divorced or separated out of any family setting.

It is emphasized that "single" and "divorced" do not pertain to marital status alone. Divorced or separated persons living with parents or siblings are categorized in the "parental" and "sibling" groups. "Parental," "marital" and "sibling" may be grouped together as "in a family setting"; "single" and "divorced" may be grouped together as "out of family setting."

This classification is adopted out of both psychiatric and sociological considerations. The location of a person's residence is partially dependent upon the type of family setting in which he is living.<sup>9</sup> On the other hand, the family setting of the schizophrenic has a meaningful relationship to his personality development and adjustment to his psychopathology in terms of the following conceptual framework:

Schizophrenia is a syndrome in which growing out of the parental family into adult independent social living is a crucial problem. In clinical experience it has been observed that male schizophrenics usually become acutely disturbed while immersed in prolonged daily interactions within their anxiety-productive parental situations. Some schizophrenics get out of this parental setting by developing an isolated social existence in which antagonistic, resentful feelings and relationships enhance their dissociation. A few schizophrenics are able to achieve, at least temporarily, conventional successful movement out of the parental home. They marry and form new family settings. Of these, some maintain at least superficially satisfactory relationships up to and after their breakdowns. Others of this group sever their marriage relation-



ships prior to manifest disturbance. These either return to close association with significant figures of the parental family, most usually with the mother, or they join the dissociated single group.

## 2. Residential Instability

In order to evaluate the role of residential instability or mobility, residence histories were obtained from social case material in the clinical charts, supplemented by interview and/or correspondence with patients, ex-patients or their relatives. Residence histories were obtained for 146 of the 305 cases. In order to evaluate possible bias in the residence history sample, diagnosis, nativity, age at time of first admission, and family setting of the group of cases with residence histories and those without residence histories were compared. As there were no significant differences in these important variables, the residence history sample can meaningfully represent the total study population (Table 1). The data were organized in the following categories—both for one year and

Table 1. Patients with Residence Histories Compared with the Patients without Residence Histories in Family Settings, Types of Schizophrenia, Ages at Times of First Admissions and in Their Nativities.

Family setting	Residence history group Percentages	Without residence histories Percentages
Living alone.....	23	19
Parental .....	60	56
Marital .....	14	19
Sibling .....	3	6
Type of schizophrenia		
Paranoid .....	30	34
Catatonic .....	22	16
Hebephrenic .....	13	6
Simple .....	9	7
"Other types" .....	21	29
Undetermined .....	5	7
Ages at times of first admission	Years	Years
Living alone .....	32.2	34.1
Parental .....	25.0	25.2
Marital .....	35.8	34.5
Sibling .....	34.7	34
Nativity	Percentages	Percentages
Foreign born .....	17	14
Native born of a foreign-born parent..	54	57
Native born of native-born parents...	28	29



five years before admission: (a) Residence same as at admission. (b) Residence in Worcester but not at the same address as at admission. (c) Not in Worcester.

The residence at birth was categorized simply as "born in Worcester" and "not born in Worcester."

Finally, a map showing the Worcester residence of each subject was made. These maps were used to determine whether the several residences were in the same areas of the city or in areas with similar general living conditions (see following).

### 3. *Population and Housing Data*

Data on population and housing were obtained from a study reported and published by the Worcester Recreation Committee.<sup>10</sup>

*Housing conditions.* The wards of the city were divided into 25 zones, and an overall rating of favorability in regard to housing was assigned to each of them. This rating was a composite of four indices which are: (1) Rent. (2) Lack of bath or need of major repairs. (3) Number of dwelling units per structure. (4) Percentage of units owner-occupied.

These 25 subdivisions each received a qualitative rating, highest, high, average, low, lowest. These five ratings of favorability of housing were assigned consecutive numerical values for the purpose of this study, from 5 for highest favorability to one for the lowest. It is assumed here that the quality of housing gives a fair presentation of general social conditions<sup>11\*</sup> for the different subdivisions of the city. Interestingly, the housing pattern of Worcester almost perfectly follows the "typical ecological pattern."<sup>12</sup> The ward divisions in the one-mile zone had the lowest ratings, in the two-mile zones, low or average ratings and in the three-mile and four-mile zones high and highest ratings. As the present writers' data are collected by wards, a composite index of each ward was obtained by taking the sum of the products of each ward subdivision housing rating and its population and dividing by the total

\*As an example of how quality of housing is reflected in social living, the Worcester Recreation Committee (Ref. 13) offers data indicating that the amount of services rendered by volunteer agencies (Boy Scouts, Girl Scouts, Boys' and Girls' Clubs, Youth Center, Y. M. C. A. and Y. W. C. A.) to people from the 25 ward subdivisions was highly correlated ( $\rho = .98$ ,  $p = < .001$ —authors' statistics from published raw data, Ref. 13) with ratings of housing in these ward subdivisions. In other words, individuals from the better housing areas (mostly adolescents and young adults) make most use of these sources of recreation and group activity; those from the poorer housing areas make the least use of them.



ward population. Rates per 10,000 of population over 14 years of age were calculated by wards, using data from the 1940 census. An approximation of the population in the one-mile zone was made by adding the populations of all ward subdivisions which are completely in this zone plus an approximation of the percentages of the populations of those ward subdivisions which partially enter the one-mile zone.\*

#### 4. *Organization of Data*

The number of patients from each mile zone and the ward rates of admission were obtained for the total study population and according to each category of family setting. Similarly, residential instability or mobility was determined for the total study population and according to each of the categories of family setting.

### RESULTS

#### 1. *Distribution, Ward Rates and Residential Instability in the Total Study Population*

Taken *in toto*, the male schizophrenics were distributed throughout the mile zones of Worcester in accord with findings of prior ecological studies. The highest rates occurred in the centrally located ward divisions of the city which have the poorest general living conditions; and the rates for 10 wards are highly significantly correlated ( $r = -.85$ ;  $p = <.001$ ) with the measures of favorability of housing.

Residential mobility played a minor role in determining the residence at admission of the total study population. At one year before admission, 75 per cent of the patients were at their admission residences. Eighteen patients, another 12 per cent, were at different addresses in Worcester, but almost all of them (16 of 18) were in the same neighborhoods or in neighborhoods with the same housing ratings. Five years before admission, 52 per cent, were at their admission addresses; 24 per cent were at different addresses in Worcester, but two-thirds of these (24 of 35) are in the same or in similar neighborhoods. In summation, one year before admission, 86 per cent, and five years before admission, 69 per cent, were at their admission addresses or similar residential areas.

\*As Worcester, Mass., is not a census tract city, this basis for delimiting subcommunities and determining hospitalization rates was not used.



## 2. *Distribution, Ward Rates, and Residential Instability in Relation to Family Setting at Times of First Admission*

Of the patients studied, 79 per cent were living in some family setting at the times of their first admissions. These cases show only a slight (statistically not significant, chi square = 3.24 and  $p = <.50 >.30$ ) tendency toward concentration in the central mile zone of the city. The correlation between the rates for the persons who were living in a family setting and the housing characteristics of the wards in which they were residing is not statistically significant ( $r = -.54$ ;  $p = <.20$ ).

Only 21 per cent of the patients studied were living in non-family settings at the times of first admissions. These cases show a marked central concentration (statistically highly significant, chi square = 34.2;  $p = <.001$ ). The correlation for the ward rates of these cases and the ward housing ratings is statistically highly significant ( $r = -.80$ ;  $p = <.001$ ).

Those patients who were living in any family setting at the time of their first admissions showed striking residential *stability*; 95 per cent at a year before admission, and 81 per cent at five years before admission were at the same addresses or in similar residences as at admission. Of these cases, 76 per cent were born in Worcester. In contrast, the patients who were not living in family settings at the times of their first admissions showed striking residential *instability*. Of these persons, 50 per cent were living in Worcester a year before admission and only 29 per cent were residents of Worcester five years before admission. Only 13 per cent of these patients were born in Worcester.

The data and statistics are given in Tables 2, 3 and 4.

Table 2

(a) Distribution of cases by mile zones and family setting							
	Family setting			Total	Non-family setting		
	Marital	Parental	Sibling		Single	Divorced	Total
All cases							
1st mile zone	23	80	5	108	48	6	54
2nd mile zone	21	64	3	88	9	1	10
3rd mile zone	4	22	5	31	..	..	..
4th mile zone	4	7	..	11	..	1	1
5th mile zone	..	2	..	2	..	..	..
Totals	52	175	13	240	57	8	65
							305



(b) Observed and expected\* number of cases in the one mile zone

	Family setting			Non-family setting	
	Marital	Parental	Sibling	Single	Divorced
Observed	23	80	5	48	6
Expected	19.8	66.5	4.94	21.6	3.4
Chi square = 3.25; $p = <.50> .30$			Chi square = 34.2; $p = <.001$		

\*Based on the approximation that 38 per cent of the population live in the one-mile zone.

## DISCUSSION

The data suggested that both central concentration and the correlation between living conditions and hospitalization rates are largely due to the residential pattern and spatial mobility of a minority of patients—those who are living alone at the time of their first admissions. When these cases are excluded from the

Table 3. Housing Characteristics and Ward Rates of First Admission Male Schizophrenics per 10,000 Population Over 14 Years of Age

Ward	Population	Housing favor- ability rating	Total cases	Total rates	Family cases	Family rates	Non- family cases	Non- family rates
I	15,400	4.3	19	1.23	19	1.23	0	.000
II	18,700	3.4	27	1.44	25	1.34	2	.107
III	25,600	1.2	58	2.27	33	1.29	25	.977
IV	24,400	2.8	39	1.60	38	1.56	1	.041
V	19,800	1.5	29	1.46	25	1.26	4	.202
VI	16,800	3.0	27	1.61	26	1.55	1	.060
VII	15,600	3.5	19	1.22	19	1.22	0	.000
VIII	13,950	1.8	31	2.22	17	1.22	14	1.000
IX	16,500	2.6	37	2.24	26	1.58	11	.667
X	14,400	3.7	19	1.32	15	1.04	4	.278

Pearsonian coefficients of correlation of housing ratings and—

- a. total case rates  $r = -.85$ ;  $p = <.001$
- b. family-setting cases  $r = -.54$ ;  $p = <.20> .10$
- c. out-of-family-setting cases  $r = -.80$ ;  $p = <.001$

total study population, the distribution of cases and rates does not differ significantly from that which would occur by chance or in a random fashion.

Rooming houses or sleeping rooms for men who are living alone tend to be located in the central, poor housing areas of the city. As early studies of urban sociology have pointed out, this is probably a function of the growth and differentiation of the city.<sup>14</sup> Single or divorced men may be said to have "drifted" out of a va-



Table 4. Family Settings at the Times of First Admissions and Residences of Cases, One and Five Years Prior to Hospitalizations; and Residences at Birth

Prior residences	Total		Family		Non-family	
	No.	Per cent	No.	Per cent	No.	Per cent
<i>1 year</i>						
Same .....	108	74.0	95	83*	13	40.6
Different .....	18	12.3	15	13	3	9.4
(Different address but in a housing area similar to that of the address at admission) .....	(16)	(10.4)	(14)	(12)	(2)	(6.4)
Out of city .....	20	13.7	4	4*	16	50.0
<i>5 years</i>						
Same .....	75	52.0	73	64.6*	2	6.5
Different .....	35	24.4	28	24.9	7	22.6
(Different housing area, but similar to admission address)....	(24)	(16.7)	(19)	(16.8)	(5)	(15.7)
Out of city .....	34	23.6	12	10.6*	22	71.0
<i>At birth</i>						
Worcester .....	83	59.0	78	75.6*	5	13.2
Out of Worcester .....	58	41.0	25	24.4*	33	86.8

\*The evident differences between the family-setting and out-of-family-setting cases are all highly significant  $p = < .001$ .

riety of living conditions into the central deteriorated areas of the city which offer them housing.

These findings have certain limited psychiatric implications.

(a) There does not seem to be any relationship between the location or the quality of external living conditions of the families of these patients, and the development of schizophrenia. This is consistent with psychiatric experience, particularly in private institutions where wealthy, suburban, well-aculturated, but very sick schizophrenics often are treated. If the sample were enlarged to include patients from private institutions, the writers would predict that the correlation between the rates for the family setting groups and (poorness of) housing conditions would be lower than the statistically non-significant figure obtained here.

(b) It is plausible that, for the persons who are living alone, the necessity of finding housing in the deteriorated, central, highly mobile areas of the city may play some role in enhancing or precipitating overt symptomatology. Psychiatric experience suggests the alternative hypothesis—that these individuals are probably protected from becoming involved in new, disruptive interpersonal relationships by living in these surroundings. One might speculate



that an additional major mode of protection from disturbing close relationships for the single and divorced schizophrenic is the avoidance of meaningful communications or relationships through residential instability.

(c) The findings of this study do not contradict the notion that social structure plays a significant role in the development of personality and psychopathology. Indeed, the writers would suggest that it is most profitable to investigate the subtle, immediate or personalized aspects of social experience and structure. A number of studies have indicated that the immediate, primary group<sup>15, 16</sup> and familial<sup>7, 8</sup> structures are highly relevant to the manifestation of psychopathology.

(d) This study suggests the hypothesis that the family structures which are relevantly associated with schizophrenia are not associated with location in the ecological structure, nor are they correlated with gross measures of the "favorability of living," in the different areas of the city.

#### SUMMARY

1. The residences of 305 first admissions, male schizophrenics admitted to Worcester (Mass.) State Hospital from Worcester between 1931 and 1950 were located and marked on a street map. Separate mappings were made according to the family setting the patients were living in at this time, e. g., living with parents, siblings, wives, or living alone.

2. There is a "typical ecological distribution" of the total study population. A marked central concentration of cases and rates, and a highly significant (negative) correlation between the rates of first admission male schizophrenics from each ward of the city and measures of "favorability of living" for that ward were noted.

3. The data were analyzed according to the family setting the patient was living in at the time of his first admission. It was then evident that the over-all typical ecological pattern is based on the residential pattern of a minority of patients, the single, separated or divorced men living alone. These patients were markedly concentrated in the central areas of the city, and the rates by wards for them were significantly (negatively) correlated with measures of "favorability of living" in the wards.

4. The majority of patients, however, were living in some family setting at the times of their first admissions, i. e., with their



parents, wives or siblings. These patients were distributed without significant central concentration, and the rates for them by wards were not significantly correlated with measures of the "favorability of living" of the wards.

5. Residence history material indicated that there was greater residential instability for the patients who were living alone at the times of their first admissions than for those who were living in some family setting. The patients who came to the hospital out of a family setting showed striking residential stability, in contrast. This suggests that the over-all central concentration of male schizophrenics is caused by the "drifting" or instability of the single and divorced men, who have moved away from their family settings into the central, deteriorated areas of the city which offer them residential facilities. The interpretation was offered that residential instability may serve as a mode of protection, for these schizophrenic men, against becoming involved in close interpersonal relationships.

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# THE IMPORTANCE OF CULTURAL EVALUATION IN PSYCHIATRIC DIAGNOSIS AND TREATMENT

BY STELLA CHESS, M. D., KENNETH B. CLARK, Ph.D., AND  
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The cultural approach to personality has been for the most part concerned with collecting evidence to demonstrate that there is a dynamic interaction between the human organism and its culture and that the personality is patterned in terms of the nature of this interaction and the milieu within which it takes place. Kluckhohn and Murray,<sup>1</sup> in discussing group membership determinants of personality, state this point of view clearly:

"The members of any organized enduring group tend to manifest certain personality traits more frequently than do members of other groups. . . . In distinguishing group-membership determinants, one must usually take account of a concentric order of social groups to which the individual belongs, ranging from large national or international groups down to small local units. . . . Not only the action patterns, but also the motivational systems of individuals are influenced by culture."

This orientation to the problems of personality evaluation does not seem to have influenced thinking and practices in the field of clinical diagnosis and treatment of disturbed personalities to the same degree and rate with which it has permeated the more academic theoretical approaches to personality. Very little direct evidence in support of the cultural approach to personality has come from the vast literature of clinical psychiatry. Among the reasons for this may be the strong influence of the Freudian instinctual theory of human personality. In addition, the criteria for psychiatric diagnosis and classification are too often taught to the student in an abstract, generalized fashion, without the concept that to ignore the cultural milieu of the patient may lead to incorrect evaluation of these criteria and incorrect diagnosis.

This paper will attempt to demonstrate that these diagnostic categories cannot be rigidly applied without taking into account the social situation within which the patient developed and seeks to function. It is the intention of this paper to illustrate the fact that the usual psychiatric criteria for evaluating personality are of dubious value if they are not used with the understanding that the same overt behavior patterns may mean very different things in different people and reflect different psychodynamics in indi-



viduals functioning in different situations, and in individuals from different cultural backgrounds. The experience gained at the Northside Center for Child Development, a child guidance center which serves children in the Harlem community of New York City, is used as a basis of discussion.

The children seen in this center come from different cultural, racial, religious, economic and social backgrounds. Not only are the children and their families of different racial, national and religious backgrounds, but the professional staff is also interracial and intercultural. The experience at the Northside Center during the past five years has provided rich case data which seem pertinent to the problem of the effects of cultural factors on psychiatric diagnosis and treatment. These data show that it is necessary to understand the cultural background and context within which the individual has developed and is seeking to function, not only to make a more precise diagnosis of his problems, but also to evaluate effectively the processes, stages and rate of progress in therapy. It is believed that this insight can lead to more effective clinical procedures in psychiatry, as well as to presenting evidence in support of an objective and realistic theory of the relation between culture and personality.

In the pursuit of evidence related to the problems of culture and personality, one must be careful not to fall into some rather obvious and some more insidious pitfalls in interpretation. One of the most glaring pitfalls found in some of the literature is the tendency to make sweeping generalizations concerning culturally-determined differences in behavior patterns which are not backed up by evidence, but are arrived at by apparently rigid preconceptions of the author. These are not unlike the layman's stereotypes extended into allegedly scientific articles. An example of this type of thinking is found in an article by Hunt<sup>2</sup> in which he attempted to show that: "... the psychoneuroses, while occurring among Negroes, were relatively less frequent in the Negro group than in the white group. The psychological conflicts of the Negro group seemed of a more simple, elementary nature resulting in the less complex type of symptomatology typical of sociopathic behavior, emotional instability, inadequate personality, simple maladjustment, and temperamental unsuitability. The tortuous, intricately structured mechanisms typical of psychoneurosis seemed to be less common."



The possibility that this difference might not be a real or significant one, but rather a reflection of a lack of rapport between a white diagnosing officer (the patients were white and Negro sailors at a psychiatric unit of a large naval installation during the last war) and Negro patients; or that it might reflect lack of ability on the part of the diagnosing person to bridge the cultural gap between Negroes and whites and understand that there may be some variations in symptom-expressions of neuroses in Negroes is not considered and discussed by Hunt. Instead he attempts to justify his position without appropriate evidence that psychoneuroses are correlated with high education, high intelligence and social superiority; and that psychiatric disturbances among Negroes—and emphasizing his stereotyped thinking in reference to Negroes in general, he adds, “culturally handicapped whites as well”—are not frequently diagnosable as neurotic and “do not resemble the classical picture of hysteria, but rather the behavior of an extremely suggestible, uncritical, emotionally unstable individual.” He does not describe the picture of “classical hysteria” or does he tell under what conditions these “classical” cases may be observed outside of textbooks, but he concludes: “Under these circumstances, a diagnosis of emotional instability, seems more fitting than one of true hysteria or conversion neurosis.” Needless to say, such studies contribute little to our understanding of the complex problems involved in an understanding of the relations between cultural factors and personality organization and disorganization.

In contrast to this, Ripley and Wolf<sup>3</sup> state that the incidence of psychoneuroses and psychoses was found to be appreciably higher among Negro than white troops. These authors also indulge in rash generalizations concerning the racial differences between Negro and white troops in “certain observable emotional and intellectual characteristics.” Among the authorities they cite in support of their observations, are some individuals who published speculative articles on this problem in 1914.

Stevens,<sup>4</sup> on the other hand, calls attention to some of the real problems involved in the psychiatric approach to the emotional problems of Negro soldiers. He believes that the crucial racial factor to be taken into account in the understanding of the psychiatric problems of the Negro soldier was the existence of racial segregation in the armed services. He states:



"Although the effect of segregation on the Negro inductee was not dramatic and immediate, it was continuous. It produced an emotional cancer, whose growth depended to a great extent on the other important racial factor, discrimination." These factors influenced not only the soldier's morale and general adjustment to the army, but also his relations with army psychiatrists. According to Stevens, army psychiatrists differed markedly in their understanding of the emotional problems of Negroes when those problems were related to social factors. Stevens says: "One psychiatrist, after offering a rather dogmatic opinion concerning the Negro to a small group discussing this subject, admitted that his knowledge was the result of eight years of contact with his office maid, who was a disciple of Father Divine. Another, after drawing a broad conclusion concerning Negro soldiers, admitted that his conclusion was based to a great extent on contact with six Negro members of a religious cult. . . . Certainly many fail to understand that a history of intermittent school attendance and frequent changes of jobs is not in some communities indicative of emotional instability, but the result of an effort to survive."

Verin,<sup>5</sup> and Houwink<sup>6</sup> point in realistic terms to the significance of the color and culture factor in a social case work relationship between Negro patients and white workers.

Davis,<sup>7</sup> Davis and Havighurst,<sup>8</sup> and Brenman<sup>9</sup> have demonstrated that there are significant differences in patterns of personality adjustment according to social class among Negroes. That variation in adjustment in terms of class position is not peculiar to Negroes, but is found also among whites, is established by a substantial bulk of objective sociological research.

The more subtle error of underdiagnosis or minimizing the personality problems of individuals of a different culture might also be avoided with a more realistic and objective understanding of the effects of cultural factors on personality adjustment. It is likely that a psychiatrist who was insensitive to those factors and who had accepted the existing racial stereotypes would assume when confronted with really disturbed Negroes who manifested psychotic patterns that these were merely manifestations of the normal "racial characteristics" of these people.

Ripley and Wolf<sup>3</sup> state: "It is a common but probably mistaken idea that it is usual for normal Negroes to hear voices or see visions." In spite of their recognition of the probability of this



being a mistaken idea, they continue a discussion of this problem, quoting from O'Malley who published an article in 1914 ("Psychoses in the Colored Race" in the *American Journal of Insanity*, 71, 309-337): "However, certain psychological differences between the Negro and white man that bear on this question, have been described. O'Malley found that Negroes are superstitious, changeable in impulse and emotional, lacking in grasp of abstract ideas and tend to transform the visionary into reality in such a way that the transition between real, supernatural, and hallucinatory experiences is difficult to establish in many cases. Lewis and Hubbard (*Manic-Depressive Psychoses*, Williams & Wilkins, Baltimore, 1931, Chap. 38, pp. 779-816) found that the American Negro, in contrast to more highly civilized races, shows a comparative lack of self-consciousness, draws a fainter line of demarcation between will and destiny, illusion and knowledge, and dreams and facts, and makes less distinction between hallucinations and objective existence."

This is clearly the ordinary variety of racial prejudices and stereotypes disguised as scientific psychiatric interpretation.

This type of pseudo-scientific distortion in the thinking of psychiatrists may do irreparable harm if the individuals having these prejudices are charged with the responsibility of providing therapy for minority group members assigned to them.

It is, therefore, most important to attempt to demonstrate the objective relationship between culture and personality.

### *Illustrative Cases*

The following cases from the records of the Northside Center are presented as typical examples of the fundamental ways in which differences in cultural backgrounds influence the weight and evaluation given specific personality patterns in psychiatric diagnosis and therapy.

*Case 1.* Jane was an attractive seven and one-half-year-old Negro girl who was brought to the Northside Center because of nervousness, forgetfulness, and confusion about family relationships. She tended to be domineering with playmates, but with adults was talkative and friendly in an indiscriminate fashion. She came from a broken home, and had lived in two different foster homes. The first foster parents complained that she was aggressive and unmanageable. The confusion about family relationships



was very understandable. Not only had she lived in three different homes, but she and her sister, who lived a block away, used the different surnames of their respective foster parents. Also Jane's foster parents from time to time cared for other temporary foster children, and during their residence in the household these children were called sisters and brothers.

In play therapy she showed compulsively neat activity with each toy, but disorganized, disconnected and confused play with an inability to sustain any one theme, and easy distractability by outside stimuli. Her verbalizations were facile and the psychiatrist felt that Jane made only a superficial relationship to her.

The differential diagnosis was between neurotic personality with confusion as to identity, and psychopathic personality. After two months of weekly play therapy sessions, she began to show silly, buffoonish and "sassy" behavior, alternating with ingratiation. The therapist's questions were either ignored, mimicked or ridiculed. This behavior continued for the next three months, and the therapist finally considered her inaccessible to therapy, with the diagnosis of psychopathic personality. The therapist recommended that therapy be discontinued. However, at this time, a report of the child's outside living-relationship gave an entirely different perspective on the results of treatment. The report indicated that the child had improved dramatically and markedly in every area of functioning. It was clear that the therapist's evaluation had been completely incorrect; and discussion of the case revealed that the therapist, a white woman, was judging the child's reactions to her, without giving adequate consideration to the fact that the child was Negro and that this would profoundly influence her reactions to any white person. In terms of the hostile, unbridgeable gap that this Negro child felt between her and any white woman, the development of this buffoonish behavior actually represented a movement toward the therapist. Her "carrying on" in this flippant manner was her manner of establishing a relationship with this hitherto awesome, threatening figure, rather than an inability to establish a relationship.

*Case 2.* Edward was an eight-year-old Negro boy, referred to the center with a variety of symptoms and fears in his school situation. He wet himself in school, didn't play with the other children, would not read, and was afraid of the teacher. At home, he manifested none of this behavior.



His symptoms were intense, and ordinarily would have been considered evidence of serious emotional disturbance. However, evaluation in terms of social setting shed different light on them. His family had recently come from the South, where they had been sharecroppers and had lived on a marginal income. They had had a number of fear-inspiring experiences with white people, in which they were cheated, threatened, intimidated and terrorized. Edward, like the rest of the family, had been taught not to fight back with white people, and to exercise the greatest care not even to express his thoughts and feelings to them. In New York he found himself in a strange, bewildering school set-up, and had a white teacher for the first time. In terms of his experiences and conditioning with white authority figures, it was normal for him to be fearful, afraid to ask questions, and even afraid to ask permission to go to the toilet. It is not strange that he could neither learn nor hold his own with the other children in such a setting.

The final diagnosis was a situational reaction in an essentially normal boy. This diagnosis was confirmed by the rapid strides he made in treatment, which included active work with the school.

*Case 3.* Arnold was a 12-year-old Negro boy, referred to the center because of delinquent behavior, which included stealing a car in company with his 15-year-old brother and another boy to go joy riding. His previous history included entering a friend's home and taking a loaded pistol, which was then discharged, wounding him in the left wrist. Had he been a middle class white boy the diagnosis of psychopathic personality undoubtedly would have been made. There was a history of repeated delinquent behavior plus several accidents while hitching rides. He showed no anxiety or defensiveness when questioned about his delinquencies. When asked what was wrong in what he did, his answer was that they should have abandoned the car in Central Park, then they wouldn't have been caught. His first contact with the therapist was superficial, and his attendance record at therapeutic sessions was poor. However, in view of his social environment, in which group activity and identification centered around gangs, the psychopathic personality diagnosis was rejected. He had exhibited a sense of responsibility, according to his standards, by trying to dissuade his brother from stealing the car with the others because his brother was already on parole. He was loyal to his gang—his subgroup. Also, in the therapeutic sessions he did at-



tend, he did show good object relationships and worked effectively.

The writers' initial experience at Northside Center with the necessity of evaluating diagnosis in terms of the concept that personality development is an integral part of the social and cultural background was seen in the case of Jane. The case illustration here is so very vivid because the criteria applied did not take these social factors into consideration; and diagnosis, method of treatment and prognosis were all inaccurately judged. The validity of the re-evaluation was proved by the fact that it correctly prognosticated the excellent progress which took place.

The two other cases illustrate the use of the knowledge acquired in scrutiny of the center's methods, stimulated by Jane's case. It has become the custom never to make a diagnosis unless some member of the staff is present who is familiar with the particular cultural background. If this cannot be achieved, the center has sought other people in the field who are familiar with the particular cultural background, and asked their participation. From this experience, Arnold for example, could not be seen as a psychopathic child in view of his high degree of conformity with the ethics, activities and mutual responsibilities of his particular group.

Edward also could not possibly have been accurately evaluated if his behavior in school had been judged on a level with that of a child whose background had not included this boy's living experiences. A white northern, urban middle class boy showing Edward's degree of fear of the teacher, to the extent of becoming intellectually paralyzed and inarticulate, would have had to be a very sick boy having exceedingly destructive total relationships. A Negro boy brought up in Georgia, whose own family and close relatives had suffered humiliation, deprivation, and cheating from white employers, with no possibilities of successful defense, is certainly expressing bewilderment by his behavior. However, considering the fact that he is transferred to a white teacher, the first in his experience, panic, defensive guardedness and retreat into non-activity, do not have the same serious pathological implications as for a child from a different environment, and the symptoms are more amenable to successful alteration.

Thus, the writers have come to feel that unless the social milieu in which the patient functions is understood and given adequate consideration, significant errors in psychiatric diagnosis, prognos-



sis and evaluation of treatment will occur. This conclusion grew inevitably out of work with patients whose social environments differed sharply from those of the white middle class groups who have provided the dominant source for psychiatric studies. The same type of errors should therefore, tend to occur in psychiatric work with other groups in which there is marked difference in cultural setting from this dominant source.

Davis<sup>10</sup> in a speech before the Mid-Century White House Conference on Children and Youth in Washington, in December 1950, stated: "The vast store of ability in millions of children in the lower socio-economic groups is largely wasted because their teachers do not understand the basic cultural habits of the working groups."

Professor Davis pointed out that the majority of our children in the public schools come from the lower socio-economic groups, while 95 per cent of the teachers are from the middle socio-economic groups and that this results in a great cultural gap. Among the results of this cultural discrepancy is the tendency of "middle class teachers, clinicians and psychiatrists" to label as "delinquent behavior," patterns in these children which are to them realistic, adaptative and socially acceptable responses to their cultural reality. He stated: "In lower class families, physical aggression is as much a normal, socially approved, and socially inculcated type of behavior as it is in frontier communities."

Another special situation occurred in the armed forces during World War II. Here, millions of civilian young men found themselves suddenly transplanted into an environment basically different, especially under combat conditions, from that in which they had developed and lived. It is not surprising, therefore, that many of the psychiatric reports from the wartime army questioned the adequacy and even the validity of the standard psychiatric criteria. Thus, Plesset<sup>11</sup> reported on the infantry division which, when it went overseas, included 138 soldiers with diagnoses of psychoneurosis or constitutional psychopathic state. None had received any intensive therapy, most had had only one brief diagnostic interview, and 25 were considered especially poor risks. Plesset anticipated seeing most of the group of 138 as patients in the first few days of combat, if not earlier. However, after 30 days of combat under winter conditions, fighting and living in snow and mud, only one was evacuated for "exhaustion." After



60 days of combat, three others were evacuated, leaving 134 still active on combat duty, and, in the subsequent three months, there were no further psychiatric casualties from this group. Raines,<sup>12</sup> reporting on psychiatric experience in the navy early in the war, declares, "When we were thrown into this cold, shortly after the onset of the war, and attempted to approach the problem with the standard and accepted psychiatric theories, we found ourselves in a predicament. We found specifically that the better trained the psychiatrist was, the fewer combat fatigue patients he seemed to get well. That was rather startling."

Wright,<sup>13</sup> found that the study of the psychological reactions of aerial crews in combat "has shown most strikingly that psychodynamic phenomena cannot be thought of in a valid or productive way outside of their situational contexts." He also reported the experience of seeing many men who were considered neurotic and inadequate function effectively in combat, and, on the other hand, seeing many previously unusually well-integrated personalities break down with severe neurotic disturbances. In the Tunisian campaign, Spiegel<sup>14</sup> found that, "A state of tension and anxiety is so prevalent in the front lines that it must be regarded as a normal reaction in this grossly abnormal situation. . . . A tense, tremulous soldier was not necessarily a psychiatric casualty. He was if we made him one and sent him back, but often he was not a casualty, simply because he was not permitted to be one." Finally, Maskin<sup>15</sup> reported how in a combat division the diagnosis of psychoneurosis and combat exhaustion was determined by all sorts of environmental factors.

Thus, it is indicated that it was not possible to apply without qualification the standard psychiatric criteria for diagnosis, treatment and prognosis to psychiatric problems in the wartime army. On the basis of experience at Northside Center, it is suggested that this confusion occurred because the environmental conditions in combat were so radically altered from those in which the psychiatric criteria had been developed that these criteria were no longer accurate.

Finally, it can be noted that in the field of psychological testing, leading workers are now emphasizing the decisive influence of cultural and environmental factors in determining test results. As summarized by Klineberg,<sup>16</sup> "The history of the mental testing of



ethnic or racial groups may almost be described as a progressive disillusionment with tests as measures of native ability, and a gradually increasing realization of the many complex environmental factors which enter into the results." This same point is made even more sharply by Goodenough and Harris:<sup>17</sup> "The search for a culture-free test, whether of intelligence, artistic ability, personal-social characteristics, or any other measurable trait is illusory, and . . . the naïve assumption that the mere freedom from verbal requirements renders a test equally suitable for all groups is no longer tenable."

To generalize, the concept that personality emerges only in terms of its social setting means that an evaluation of the healthy or morbid psychological aspects of an individual can be made only in terms of what is appropriate and effective functioning within the specific cultural milieu. If this principle is not kept in mind, then the frequent difference between patient and psychiatrists in social, economic, or cultural status will lead the psychiatrist to make the error of using his own status as the norm and that of the patient, if different, as the deviation from the norm. Where the patient has undergone a change in cultural environment, a lag in adaptation to the new circumstances, while possibly annoying and incomprehensible to various figures in the new environment, cannot be justifiably equated with morbidity of personality structure. On the other hand, severe deviations cannot be lumped under the heading of lag in adaptation. The judgment can be made accurately only by an examiner who is already familiar with, or makes himself cognizant of, those cultural factors which were an integral part of the development of personality, and who also is familiar with the personality types developing as the norms of the patient's cultural group.

As can be seen, the discussion has moved from a consideration of diagnostic criteria to an examination of personality development. The experiences reported and the views cited are incompatible with the approach to personality in terms of a basic fixed human nature or of a racist approach to variation in human behavior. It is the purpose of this paper to indicate the errors in diagnosis and management in treatment that can result from such an approach, and to suggest the necessity of evaluation in cultural terms if these errors are to be avoided.



## SUMMARY

Experience at a child guidance center with patients drawn from varying national and racial backgrounds shows the necessity for evaluating cultural factors for accurate diagnosis and optimum treatment. A number of case histories are reported in which there were significant cultural differences between the patient and the examiner or therapist, and where appreciable errors of diagnosis and evaluation of treatment occurred, or were under consideration, because the examiner or therapist was not sufficiently aware of these cultural differences and their manifestations.

A number of psychiatric reports are also cited from World War II which noted difficulties when standard psychiatric criteria from civilian life were applied without taking into account the radically different cultural setting in the war-time army. A similar development is reported in the field of psychological testing, where leading workers have become increasingly aware of the decisive importance played by cultural factors in determining test results. The theoretical implications of these findings regarding the significance of the cultural factors in psychiatric evaluation are discussed.

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# THE CONCEPT OF THE UNCONSCIOUS IN THE HISTORY OF MEDICAL PSYCHOLOGY\*

BY EDWARD L. MARGETTS, M. D.

## A. INTRODUCTION

Most psychiatrists nowadays, whether they utilize the concept of the unconscious in psychotherapy or not, have some working idea, however vague, of an unconscious mind, which they find useful in their theoretical frames of reference. There is a vast amount of historical fact which indicates that almost since the dawn of civilization man has had an inkling of understanding that mind activity outside of our waking consciousness does truly exist. It is not the intention here to go exhaustively into the details of such beliefs, but to mention a few specific examples in order to show that for thousands of years man has had this inkling, which, one grants, many times seems vague and incomplete. There are a great many written words describing such things as body-mind-soul, perception, stimulus-response, memory, instinct, association, dreams, and other unusual states such as trance, double personality, automatic behavior, unreality feelings, in ways that allow us to ponder the question that the understanding of unconscious processes was established long before the advent of our "modern" theories on this fascinating subject.

The word "unconscious" has a considerable number of meanings, even in current thought. The author does not intend to get himself lost in a quagmire of definitions and controversies. Every psychiatrist has as many ideas as he in this regard.<sup>1</sup> Most of the arguments propounded against the idea of an unconscious consist of rather feeble bone-picking philological negativisms such as "There are no such things as unconscious ideas—or unfelt feelings." The aim of this paper is to wander hither and yon through history, and to sift out some facts which contribute to the thesis that the unconscious is an old and oft-revised concept.

## B. THE ANCIENT WORLD

Out of ancient India came the first clear formulation of the idea of a stratified consciousness.<sup>2a, 3, 4, 5, 6a</sup> Probably the earliest work to indicate this is the *Upanishads*, a collection of documents of

\*This historical investigation was supported by a grant-in-aid from the Ciba Co., Ltd., Montreal.



about 600 B. C., which constituted a written presentation of the efforts of the Hindus to construe the world as a rational whole, and to regard the ultimate as a unification of the individual self with the Supreme Being, the Absolute, Brahma. Sanskrit scholars have written in great detail about the "type of soul," or levels of consciousness, in the Upanishads,<sup>3,4,5,7</sup> which strongly influenced such modern philosophers as Arthur Schopenhauer and Paul Carus<sup>2a</sup> who both had clear theories of unconscious mind. The Upanishads, particularly *Mandukya Upanishad* 3-11 (Ref. 5, pp. 391-3),\* set forth quite clearly the "four states of self." They are:

1. The waking state (*jagarita-sthana*): equivalent to the "conscious." In this state, man accepts the universe as he finds it. Perception, volition, and memory are preserved. This level is recognizable in the well-developed animal kingdom, including man. (According to *Vedanta* philosophy, a psyche exists in the animal, vegetable and mineral kingdoms.)

2. The dreaming state (*svapna-sthana*): the "subconscious." Here the self loses contact with reality, and the soul fashions its own world in the imagery of its dreams. The Brahmins had a very interesting conception of dreams (see *Prasna Upanishad* 4-5—Ref. 5, p. 386). The usual state of mind in the less developed animal kingdom.

3. The deep-sleep state (*susupta sthana*): a deeper level of the subconscious approaching complete unconsciousness. This is a state of bliss in which there is no contact with reality, no desire, no dreams. This is the normal situation in the vegetable and mineral kingdoms.

4. The fourth state (*caturtha, turiya, turya*): the "super- (or supra-) conscious." "According to *Vedanta*, it is in this state that Seers get flashes of Great Truths in the form of vague apprehensions, which are afterwards elaborated in the *jagrat* state or waking consciousness."<sup>8</sup> Deussen<sup>3</sup> reasoned that full appreciation of this state of soul became prominent with the rise of the Yoga school, which believes that by intense meditation and self-control, the union of the human soul with the Supreme Soul, Brahma, may be achieved, *with the maintenance of the waking consciousness*.

One wonders if ancient Egypt had much of interest to offer us, but so far as this writer is able to discover, there is little in Egyptian philosophy that bears on the subject. There were at least six

\*Accents have been omitted from Sanskrit words.



different kinds of soul which were accepted by the early inhabitants of the Nile valley, but they corresponded more to modern concepts of ego, super-ego and id than to our ideas about an unconscious. The same might be said about the three souls of Plato (427-347 B. C.) (Ref. 9: *Timaeus the Locrian*: Burges. Bohn Vol. VI, p. 160. *Timaeus* XIX, XLIV: Davis. Bohn Vol. II, pp. 349 and 380) which are treated in a similar way in the New Testament—spirit, psyche, flesh, equivalent to super-ego, ego, and id,<sup>2b</sup> and in the Egyptian *Hermetica*<sup>10</sup> and the sense of which was first clearly set forth in the *Katha Upanishad* (3. 10 and 11—Ref. 5, p. 352):

- “10. Higher than the senses are the objects of sense.  
 Higher than the objects of sense is the mind (*manas*);  
 And higher than the mind is the intellect (*buddhi*)  
 Higher than the intellect is the Great Self (*Atman*).  
 “11. Higher than the Great is the Unmanifest (*Avyakta*).  
 Higher than the Unmanifest is the Person.  
 Higher than the Person there is nothing at all.  
 That is the goal. That is the highest course.”

The idea here is that the individual soul becomes one (unified) with Brahma. (See *Brihad-Aranyaka Upanishad* 4. 4; 2.—Ref. 5, p. 139.)

Plato also set forth his waxen tablet explanation of memory, which is well known and contributes something to the matter of present interest. (Ref. 9, *Theaetetus* 118: Cary. Bohn Vol. I, p. 431.) In discussing dreams, Plato seemed to approach closer to a belief in an unconscious than he did in writing of the three souls, although in the latter he had a clear idea of what is now meant by “repression” (Ref. 9, *Timaeus* XLIV: Davis. Bohn Vol. II, p. 380). The *Republic* (XI, 1: Davis. Bohn Vol. II, p. 260) reads as follows: “Of pleasures and desires that are not necessary, some seem to me contrary to law,—which indeed seem engendered in all men:—though owing to the correction of the laws, and of improved desires aided by reason, they either forsake some men altogether, or are less numerous and feeble, while in others they are more powerful and more numerous. Will you inform me what these are? said he. Such, said I, as are excited in sleep, when the rest of the soul—which is rational, mild, and its governing principle, is asleep, and when that part which is savage and rude, being sated with food and drink, frisks about, drives away sleep, and



seeks to go and accomplish its practices;—in such an one, you know, it dares to do everything, because it is loosed and disengaged from all modesty and prudence: for, if it pleases, it scruples not at the embraces, even of a mother, or any one else, whether gods, men, or beasts; nor to commit murder, nor abstain from any sort of meat,—and in one word, it is wanting neither in folly nor shamelessness.”

To discuss the vast literature on dreams would lead far afield from the subject, and reference to the recent anthology of Woods<sup>11</sup> will give the interested reader a selection of examples derived from ancient and modern writers. Dreams and their meanings have had a great deal to do with the various formulations of mind activity outside of waking consciousness. From primitive times to the present, dream interpretation has been a part of “psychotherapy.” The best example, of course, is the incubation sleep of the temples in Egypt, Greece and Rome.

Aristotle (384-322 B. C.) came much closer to a clear appreciation of mental activity outside of consciousness than did Plato, his teacher. In the *De Memoria et Reminiscentia*,<sup>12</sup> Aristotle set forth his theories of memory, association, and mental activity of which the subject was unaware. Extracts from this work are so clear as to require but little explanation: “(450a-30). The process of movement [sensory stimulation] involved in the act of perception stamps in, as it were, a sort of impression of the percept, just as persons do who make an impression with a seal. [This simile comes from Plato, *Theaetetus*, *supra*.]\* . . . (451a-5). We can now understand why it is that sometimes, when we have such processes, based on some former act of perception, occurring in the soul, we do not know whether this really implies our having had perceptions corresponding to them, and we doubt whether the case is or is not one of memory. But occasionally it happens that [while thus doubting] we get a *sudden idea*\*\* and recollect that we heard or saw something formerly. This [occurrence of the ‘sudden idea’] happens whenever, from contemplating a mental object as absolute, one changes his point of view, and regards it as relative to something else. . . . (452a-5). It often happens that, though a person cannot recollect at the moment, yet by *seeking*\*\* he can do so, and discovers what he seeks. This he succeeds in doing by set-

\*Present writer’s comment.

\*\*Italics the present writer’s.



ting up many movements [sensory stimulations]\* until finally he excites one of a kind which will have for its sequel the fact that he wishes to recollect. . . . (452a-15). But one must get hold of a starting-point. This explains why it is that persons are supposed to recollect sometimes by starting from mnemonic *loci*. The cause is that *they pass swiftly in thought from one point to another*,\*\* e. g., from milk to white, from white to mist, and thence to moist, from which one remembers Autumn [the 'season of mists'], if this be the season he is trying to recollect.

"It seems true in general that the middle point also among all things is a good *mnemonic starting-point*\*\* from which to reach any of them. For if one does not recollect before, he will do so when he comes to this, or, if not, nothing can help him. . . . (451b-25). Thus, then, it is that persons seek to recollect, and thus, too, it is that they recollect even *without the effort of seeking to do so*,\*\* viz., when the movement implied in recollection has supervened on some other which is its condition [i. e.—non-voluntary, without effort of will]\* . . . (452a-1). Accordingly, things arranged in a fixed order, like the successive demonstrations in geometry, are easy to remember [or recollect], while badly arranged subjects are remembered with difficulty. . . . (453a-10). The cause of this is that recollection is, as it were, a mode of inference. For he who endeavors to recollect infers that he formerly saw, or heard, or had some such experience, and the process [by which he succeeds in recollecting] is, as it were, a sort of investigation."

### C. THE GLOOM OF THE DARK AGES

From the age of Greek philosophy to the Renaissance, little more was brought forth except in India, where the religious philosophers developed the ancient ideas of levels of consciousness and applied them particularly to states of meditation, trances, and so on. Farther west, the ideas of the Greeks were carried on through the Dark Ages.

Saint Augustine (354-430 A. D.), in the *Confessions*,<sup>13</sup> wrote, with fine understanding, at considerable length about memory. He described memories which could be recalled instantly, and those which took time to come to mind, being "hidden from sight," or more deeply rooted in the mind: "others must be longer sought after, which are fetched, as it were, out of some *inner receptacle*"\*\*

\*Present writer's comment

\*\*Italics the present writer's.



[X:VIII (12), Ref. 13, p. 211], c. f. *unconscious*. Elsewhere he wrote: "even when the mind doth not feel, the memory retaineth" [X:XVII (26), Ref. 13, p. 219]. Finally, he dealt with falling out of memory, seeking the recognition by part association, and complete forgetfulness. This showed an appreciation of memory levels which has never been much improved upon. The passage runs: "But what when the memory itself loses anything, as falls out when we forget and *seek*\* that we may recollect? Where in the end do we search, but in the memory itself? and there, *if one thing be perchance offered instead of another, we reject it*,"\* until what we seek meets us; and when it doth, we say, 'This is it'; which we should not unless we recognized it, nor recognize it unless we remembered it. Certainly then we had forgotten it. Or, had not the whole escaped up, but by the *part*\* whereof we had hold, was the lost part sought for; in that the memory felt that it did not carry on together all which it was wont, and maimed, as it were, by the curtailment of its ancient habit, demanded the restoration of what it missed? For instance, if we see or think of some one known to us, and having forgotten his name, try to recover it; whatever else occurs, connects itself not therewith; because it was not wont to be thought upon together with him, and therefore is rejected, until that present itself, whereon the knowledge reposes equably as its wonted object. And whence does that present itself, but out of the memory itself? for even when we recognize it, on being reminded by another, it is thence it comes. For we do not believe it as something new, but, upon recollection, allow what was named to be right. But were it *utterly blotted*\* out of the mind, we should not remember it, even when reminded. *For we have not as yet utterly forgotten that, which we remember ourselves to have forgotten*.\* What then we have utterly forgotten, though lost, we cannot even seek after" [X:XIX (28), Ref. 13, p. 221].

The great Arab physician Rhazes (864-925 A. D.) was an astute psychologist, and drew from Plato when writing of the soul and emotions. In his *Spiritual Physick*,<sup>14</sup> Rhazes applied the Platonic idea of suppression of the passions in order to maintain the health of the body. In the twelfth century, Isaac, the English-born abbot of Stella in Poitiers, apparently had an appreciation of unconscious mental activity. In writing of the soul, he pointed out "not

\*Italics the present writer's.



everything known is continually present, nor does all that a man knows remain at all times directly to the eye of the mind [*nec versatur semper in intuitu scientis omne quod scitur*]."<sup>15</sup>

#### D. THE LIGHT OF THE NEW LEARNING

During the stagnation and retrogression of the Dark Ages, there are to be found no additional illustrations of the subject with which this paper is concerned. Toward the end of the fifteenth century, born within a year of each other, two great names in medicine come to attention, and apparently both of them had an understanding of mental processes outside of awareness. They were Paracelsus (1493-1541) and Juan Luis Vives (1492-1540). Paracelsus believed that mental illness was due to unhealthy changes in the *spiritus vitae*, and rejected the prevalent demonological concept of mental illness, which in itself was no mean accomplishment for his time, since everybody believed that people became mentally ill from inhabitation of the body by demons or spirits. He offered the name "*chorea lasciva*" for St. Vitus' dance, and suggested the sexual nature of hysteria. He formulated the theory that imaginative ideas, elaborated from seeing or hearing something, were the cause of hysteria: "their sight and hearing are so strong that unconsciously they have fantasies about what they have seen or heard." According to Zilboorg (Ref. 16, p. 199) this deep insight of Paracelsus was (probably) "the first reference to the unconscious motivation of neuroses in the history of medical psychology." The Spaniard, Vives, devoted his life to education and social reform, particularly to relief for the poor and mentally ill. He clearly saw the importance of psychological associations and *recognized the emotional content that many associations carried with them*. He described in *De Anima et Vita* (1538) how ideas could be registered without our conscious knowledge and could later be discovered by association.<sup>16, 17</sup> There seems to be little doubt that these theories were directly elaborated from Aristotle.

#### E. PHILOSOPHY, PSYCHOLOGY AND MEDICINE

The seventeenth century saw the resurrection of the age-old problem of mind-body relationships. Over the next two centuries, much was to be written on this subject, and the problem gradually evolved from its situation as one of the most prominent in philosophy to one of the most intriguing in scientific psychology and in



medicine. From the psychiatric point of view, it would appear that since 1700 there have been two important peaks in the history of mind-body theories. The first was apparent as the war between psyche and soma which raged in Germany from 1800 to 1850 and which culminated in the victory of the somatic school under Jacobi and his followers.<sup>6b</sup> The second is still going on in the conflict between the adherents to the theories of psychic and those of organic causation. Why there should be such extremist viewpoints at the present day is *difficult* to understand, but *understandable*! One may suppose that only by thoroughly investigating each of them can we completely understand how the extremes may be unified into a meaningful whole, a psychobiological theory which includes every facet of man and his environment.

The writings of René Decartes (1596-1650) and John Locke (1632-1704) did much to delineate the meaning of *consciousness*, which was equated with *mind*. Following their work, the problems of psychology became largely those of consciousness. A number of thinkers who took exception to this notion were those who included in their psychology mind activity outside of consciousness. They are the ones to be discussed now.

#### F. PHILOSOPHY

One of the first philosophers to devote very much thought to the idea of an unconscious was the German, Gottfried Wilhelm Leibniz (1646-1716),<sup>18</sup> whose philosophical framework supported the thesis that ideas existed in a latent or potential (i. e., unconscious) form. For Leibniz, the world was a system of souls, or monads, which were miniature forms of the whole system. There were no connections between one monad and another; they seemed to interact only because of "pre-established harmony" between them. The inner development of each monad was so prearranged in the creation of the world that all its changes were accompanied by corresponding changes in other monads.

There was no clear-cut division between consciousness and unconsciousness. The principle of continuity was followed; the one shaded into the other—unconscious perception, (*petites perceptions*, vague and obscure ideas, subconscious activities) gradually merged with conscious apperception. We read the following in *New Essays on the Human Understanding* (1704): "Besides these are countless indications which lead us to think that there is at



every moment an infinity of *perceptions* within us, but without *ap*-perception and without reflexion; that is to say, changes in the soul itself of which we are not conscious [*s'apercevoir*], because the impressions are either too small and too numerous or too closely combined, [*trop unies*], so that each is not distinctive enough by itself, but nevertheless in combination with others each has its effect and makes itself felt, at least confusedly, in the whole (Ref. 18, p. 370).

. . . These unconscious [*insensible*] perceptions also indicate and constitute the identity of the individual, who is characterized by the traces or expressions of his previous states which these unconscious perceptions preserve, as they connect his previous states with his present state; and these unconscious perceptions may be known by a higher mind [*esprit*], although the individual himself may not be conscious of them, that is to say, though he may no longer have a definite recollection of them . . ." (Ref. 18, p. 373).

In *Principles of Nature and of Grace, Founded on Reason* (1714), Leibniz again clearly stated this idea: "Thus it is well to make distinction between *perception*, which is the inner state of the Monad representing outer things, and *apperception*, which is *consciousness* or the reflective knowledge of this inner state, and which is not given to all souls nor to the same soul at all times." (Ref. 18, p. 411.) In the *Monadology* (1714) we read: "And as, on waking from stupor, *we are conscious* of our perceptions, we must have had perceptions immediately before we awoke, although we were not at all conscious of them; for one perception can in a natural way come only from another perception, as a motion can in a natural way come only from a motion" (Ref. 18, p. 231).

An older contemporary of Leibniz was Benedict Baruch Spinoza (1632-1677). His most interesting work from the point of view of modern psychiatry was the *Ethica Ordine Geometrico Demonstrata*, first published in 1677.<sup>19</sup> This book, which included material relating to mind-body (monism), association, memory, dreaming, and the various emotions, appeared more than a quarter of a century before Leibniz wrote the essays which have already been discussed. One gathers from Spinoza that he had a conception of subconscious phenomena and their interplay with emotions. Quotations may be cited relating to sleep, association, and emotion which seem to tie together pretty well: "For when the body is asleep, the mind, at the same time, *remains unconscious*,"\* and has not the power of

\*Italics the present writer's.



thinking that it has when awake (*Ethics* III, Prop. II, Note. Boyle, p. 87). . . . And hence we can clearly understand why the mind from the thought of one thing should immediately fall upon the thought of another which has no likeness to the first (*Ethics* II, Prop. XVIII, Note. Boyle, p. 56) . . . An emotion which is a passion ceases to be a passion as soon as we form a clear and distinct idea of it . . . Therefore the more an emotion becomes known to us, the more it is within our power and the less the mind is passive to it." (*Ethics* V, Prop. III. Boyle, p. 203.)

The next philosopher who dealt in any way with mental activity outside of consciousness was Immanuel Kant (1724-1804). Hartmann<sup>20</sup> paid tribute to Kant, and on the first page of the *Philosophy of the Unconscious* (*infra*), he acknowledged his indebtedness to "the great clear thinker of Königsberg." On page 20, Hartmann quoted from Kant's *Anthropology* (1798), Section 5: "Innumerable are the sensations and perceptions *whereof we are not conscious*,\* although we must undoubtedly conclude that we have them, obscure ideas as they may be called (to be found in animals as well as in man). The clear ideas, indeed, are but an infinitely small fraction of these same exposed to consciousness. That only a few spots on the great chart of our minds are illuminated may well fill us with amazement in contemplating this nature of ours." Kant's writings are complicated and tedious to read, and even his scholarly admirers find him difficult. For instance, F. Max Müller wrote that he hoped his English translation of the *Critique of Pure Reason* (1781)<sup>21</sup> would be more intelligible to students than the German original!

However, a few passages from the *Critique*<sup>21</sup> which are pertinent to the subject should be mentioned: "We shall see hereafter that synthesis in general is the mere result of what I call the faculty of imagination, a blind but indispensable function of the soul, without which we should have no knowledge whatsoever, *but of the existence of which we are scarcely conscious*.\* But to reduce this synthesis to concepts is a function that belongs to the understanding, and by which the understanding supplies us for the first time with knowledge properly so called (p. 64). . . . This representation of a general procedure of the imagination by which a concept receives its image, I call the schema of such a concept.

\*Italics the present writer's.



"The fact is that our pure sensuous concepts do not depend on images of objects, but on schemata (p. 115). . . . this schematism of our understanding applied to phenomena and their mere form is an art *hidden in the depth of the human soul*,\* the true secrets of which we shall hardly ever be able to guess and reveal" (p. 116).

Of all the philosophers, the one who probably should receive most credit for his conception of an unconscious was Arthur Schopenhauer (1788-1860). At least he is "easy to read," which is more than can be said for most of the rest of them! Even Sigmund Freud, in *The History of the Psychoanalytic Movement*,<sup>22</sup> following up a paper by Otto Rank<sup>23</sup> was obliged to acknowledge Schopenhauer's lead in dealing with the mechanism of repression. In *Die Welt als Wille und Vorstellung*<sup>24</sup> which was first published in 1819, the following passage occurs: "The exposition of the origin of madness in the text will become more comprehensible if it is remembered how *unwillingly*\* we think of things which powerfully injure our interests, wound our pride, or interfere with our wishes; with what difficulty do we determine to lay such things before our own intellect for careful and serious investigation; how easily, on the other hand, *we unconsciously break away or sneak off from them*\* again; how, on the contrary, agreeable events come into our minds of their own accord, and, if driven away, constantly creep in again, so that we dwell on them for hours together. In that resistance of the will to allowing what is contrary to it to come under the examination of the intellect lies the place at which madness can break in upon the mind. Each new adverse event must be assimilated by the intellect, *i. e.*, it must receive a place in the system of the truths connected with our will and its interests, whatever it may have to displace that is more satisfactory. Whenever this has taken place, it already pains us much less; but this operation itself is often very *painful*,\* and also, in general, only takes place slowly and with *resistance*.\* However, the health of the mind can only continue so long as this is in each case properly carried out. If, on the contrary, in some particular case, the resistance and struggles of the will against the apprehension of some knowledge reaches such a degree that that operation is not performed in its integrity, then certain events or circumstances become for the intellect completely *suppressed*,\* because the will cannot endure the sight of them, and then, for the sake of the necessary connection,

\*Italics the present writer's.



the gaps that thus arise are filled up at pleasure; thus madness appears. For the intellect has given up its nature to please the will: the man now imagines what does not exist. Yet the madness which has thus arisen is now the lethe of unendurable suffering; it was the last remedy of harassed nature, *i. e.*, of the will. . . . In accordance with the above exposition one may thus regard the origin of madness as violent '*casting out of the mind*'\* of anything, which, however, is only possible by '*taking into the head*' something else" (Vol. III, pp. 168-9). This statement is so clear it requires no further explanation.

Schopenhauer wrote in other pages of an unconscious mental activity: ". . . let us compare our consciousness to a sheet of water of some depth. Then the distinctly conscious thoughts are merely the *surface*;\* while, on the other hand, the indistinct thoughts, the feelings, the after sensation of perceptions and of experience generally, mingled with the special disposition of our own will, which is the kernel of our being, is the *mass*\* of the water. Now the mass of the whole consciousness is more or less, in proportion to the intellectual activity, in constant motion, and what rise to the surface, in consequence of this, are the clear pictures of the fancy or the distinct, conscious thoughts expressed in words and the resolves of the will. The whole process of our thought and purpose seldom lies on the surface, that is, consists in a combination of distinctly thought judgements; although we strive against this in order that we may be able to explain our thought to ourselves and others. But ordinarily it is in the obscure depths of the mind that the rumination of the materials received from without takes place, through which they are worked up into thoughts; and it goes on almost as *unconsciously*\* as the conversion of nourishment into the humours and substance of the body. Hence it is that we can often give no account of the origin of our deepest thoughts. They are the birth of our mysterious inner life. Judgements, thoughts, purposes, rise from out that deep unexpectedly and to our own surprise. . . . Consciousness is the mere surface of our mind, of which, as of the earth, we do not know the inside, but only the crust.

"But in the last instance, or in the secret of our inner being, what sets in activity the association of thought itself, the laws of which were set forth above, is the *will*, which urges its servant the

\*Italics the present writer's.



intellect, according to the measure of its powers, to link thought to thought, to recall the similar, the contemporaneous, to recognize reasons and consequents" (Vol. II, p. 327).

The analogy of the mind to a body of water, the thin surface being conscious and the vast deep being unconscious, is interesting, because in many theories of the unconscious the same general theme of stratification has been applied. Probably the most common one is the "iceberg theory," conscious mind activity being the one-ninth of the iceberg above water level, and unconscious being the eight-ninths below the surface. This idea has been ingeniously reapplied lately by J. S. L. Browne in his concept of disease causation which he elaborated in attempting to explain the action of ACTH.<sup>25</sup> Schopenhauer wrote elsewhere: "The will, as the thing in itself, constitutes the inner, true, and indestructible nature of man; in itself, however, it is *unconscious*.\* For consciousness is conditioned by the intellect, and the intellect is a mere accident of our being; for it is a function of the brain, which, together with the nerves and spinal cord connected with it, is a mere fruit, a product, nay, so far, a parasite of the rest of the organism; for it does not directly enter into its inner constitution, but merely serves the end of self-preservation by regulating the relations of the organism to the external world" (Vol. II, p. 411). Emotion was considered an inclination which exercised a power over the will (Vol. III, p. 407).

After Schopenhauer, a very significant advance was made by Johan Friedrich Herbart (1776-1846),<sup>26</sup> who attempted to form a mathematical, scientific, and dynamic foundation for philosophy and psychology. He described how ideas came into consciousness and then passed away into the unconscious. Ideas might co-exist in consciousness or might strive against one another (conflict) and exclude others from consciousness (repression). The ejected ideas did not remain passively in the unconscious, but tried at all times to regain conscious standing. He wrote at length on "the threshold of consciousness," and described two levels, the statical and mechanical.

This very important theory allowed for unconscious concepts that affect conscious mental activity. These points will be clear from the following passages from Herbart's *Lehrbuch zur Psychologie* (1st ed. 1816; 2nd 1834. The translation of the latter<sup>26</sup> is quoted): ". . . concepts must be regarded as forces whose ef-

\*Italics the present writer's.



fectiveness depends upon their strength, their oppositions, and their combinations, all of which are different in degree (p. 6). . . . Concepts become forces when they resist one another [c. f., *conflict*].\* This resistance occurs when two or more opposed concepts encounter one another (p. 9). . . . When a sufficiency of opposition exists between concepts, the latter are in equilibrium [c. f., *homeostasis*.]\* They come only gradually to this point. The continuous change of their obscurity may be called their movement (p. 11). . . . A concept is in consciousness in so far as it is not suppressed, but is an actual representation. When it rises out of a condition of complete suppression, it enters into consciousness. Here, then, it is on the threshold of consciousness (p. 13). [This is later distinguished as the statical, as opposed to the mechanical threshold]\* . . . When to several concepts already near equilibrium [c. f., *homeostasis*]\* a new one comes, a movement arises which causes them to sink for a short time beneath their statical point, after which they quickly and entirely of themselves rise again—something as a liquid, when an object is thrown into it, first sinks and rises . . . one of the older concepts may be removed entirely out of consciousness even by a new concept that is much weaker than itself. In this case, however, the striving of the suppressed concept is not to be considered wholly ineffective . . . it works with all its force against the concepts in consciousness. Although its object is not conceived, it produces a certain condition of consciousness. The way in which these concepts are *removed out of consciousness and yet are effective therein*\*\* may be indicated by the expression, 'They are on the mechanical threshold.' The threshold mentioned above is called for the sake of distinction the statical threshold. Note—If the concepts on the statical threshold acted in the same way as on the mechanical threshold we should find ourselves in a state of the most intolerable uneasiness, or rather the body would be subjected to a condition of tension that must in a few moments prove fatal, even as under present conditions sudden fright will sometimes cause death; for all the concepts which, as we are accustomed to say, the memory preserves, and which we well know can upon the slightest occasion be reproduced, are in a state of incessant striving to rise, although the condition of consciousness is not at all affected by them" (p. 18).<sup>26</sup>

\*Present writer's comment.

\*\*Italics the present writer's.



Karl Gustav Carus (1789-1869), professor at Dresden, wrote extensively on magic, animal magnetism, and the unconscious, "the night side" of the soul. In 1846, in *Psyche: zur Entwicklungsgeschichte der Seele*,<sup>27</sup> on page 1, he wrote as follows: "The key to the recognition of the substance of the conscious soul life lies in the region of the unconscious" (*Der Schlüssel zur Erkenntniss vom Wesen des bewussten Seelenlebens liegt in der Region des Unbewusstseins*). Carus is very important to the subject of the present paper because of his use of a theory of the unconscious to investigate the common ground of philosophy and abnormal psychology (unusual mental states, magic, hypnosis).

So far, the German philosophers have been discussed at length, and it might be refreshing for a change to speak of a Scottish one, Sir William Hamilton (1788-1856), professor of logic and metaphysics at Edinburgh. He formulated the idea of "mental latency," which Mill<sup>28</sup> agreed with in principle but preferred to apply on a neurological basis. Hamilton's *Lectures on Metaphysics* were published posthumously by Mansel and Veitch.<sup>29</sup> Three different kinds of "latency" were propounded by him, and they are of great interest since he applied one type to abnormal mental states.

(1) "... the riches—the possessions, of our mind, are not to be measured by its present momentary activities, but by the amount of its acquired habits. I know a science, or language, not merely while I make a temporary use of it, but inasmuch as I can apply it when and how I will. Thus the infinitely greater part of our spiritual treasures, lies always beyond the sphere of consciousness, hid in the obscure recesses of the mind" (Vol. I, p. 339).

(2) "... when the mind contains certain systems of knowledge, or certain habits of action, which it is wholly unconscious of possessing in its ordinary state, but which are revealed to consciousness in certain extraordinary exaltations of its powers. The evidence on this point shows that the mind frequently contains whole systems of knowledge, which, though in our normal state they have faded into absolute oblivion, may, in certain abnormal states, as madness, febrile delirium, somnambulism, catalepsy, & c., flash out into luminous consciousness, and even throw into the shade of unconsciousness those other systems by which they had, for a long period, been eclipsed and even extinguished" (p. 339).

(3) "Are there, in ordinary, mental modifications,—i. e. mental activities and passivities, of which we are unconscious, but which



manifest their existence by effects of which we are conscious? . . . In the question proposed, I am not only strongly inclined to the affirmative,—nay, I do not hesitate to maintain, that what we are conscious of is constructed out of what we are not conscious of,—that our whole knowledge, in fact, is made up of the unknown and the incognisable” (p. 347).

The most broadly developed theory of an unconscious ever worked out was propounded by the German philosopher, Eduard von Hartmann (1842-1906) who, when only 27 years of age, in 1868, published the phenomenal three-volume work, *Philosophie des Unbewussten* (*Philosophy of the Unconscious*), which had a profound effect on the thought of man during the nineteenth century. Certainly most medical men of that time were familiar with it. The book was translated into English in 1884,<sup>20</sup> and is readily available, but it is surprising how few modern psychiatrists know about it. If this paper has no other effect than to stimulate some colleagues to thumb through Hartmann, the writer will feel that he has done a useful service. Hartmann was strongly influenced by Kant, as previously mentioned, and wrote (Ref. 20, p. 17) of Leibniz “making the discovery of unconscious ideas.” Hartmann assigned to the unconscious a much more important place than any previous writer. For him, it was a combination of unconscious will (cf. Schopenhauer) and unconscious idea (cf. Aristotle). Unconscious feeling, so important to modern psychological theory, he resolved into the other two elements. Hartmann unnecessarily applied his idea of the unconscious to explain many an aspect of life which could more appropriately be explained otherwise. His generalizations were broad enough to be described as “cosmic” in scope, and he has been severely criticized because of this. However, one is obliged to give this man his due; he was a pioneer, and his work is a landmark in the history of philosophy and psychology. It is appropriate that a discussion of the philosophers who have written concerning the unconscious ends with the name of Hartmann.

#### G. PSYCHOLOGY AND MEDICINE

Excluding the advances of the last 50 years, the works of psychologists, physiologists and medical men have not contributed so much to unconscious theory as those of the philosophers. However, a few names may be mentioned. The early work in these



fields came, not out of Germany, as had the philosophy, but from Scotland and France.

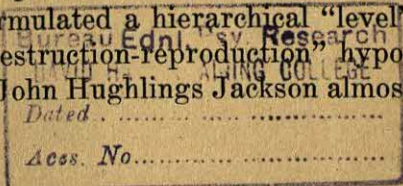
Robert Whytt (1714-1766), in *An Essay on the Vital and Involuntary Motions of Animals* (1750),<sup>30</sup> wrote: ". . . when we are solicitously engaged in any action, involved in any thought, or hurried away by any passion, we may be *unconscious*\* of the impressions made by material causes on the organs of sense; yet we cannot but be sensible of the ideas formed within us by the internal operation of our minds, because their very existence depends upon our being conscious of them, and it is at an end, as soon as either we attend not to, or forget them: to say therefore that such ideas may be formed and exist in the mind without consciousness, is, in effect, to say that they may and may not exist at the same time" (Ref. 30, p. 151). He added a footnote: "To avoid all metaphysical disputes about different degrees of consciousness, I desire it may be understood, that here and in other parts of this essay, when I say we are not conscious of certain impressions made on the mind by the action of material causes on the organs of the body, I mean no more, than that we have no such consciousness or preception of them, as either convinces us of their existence when present, or enables us, by the help of memory, to recall them when past."

The great William Cullen (1710-1813),<sup>31</sup> who succeeded Whytt at Edinburgh, wrote: "Many impressions have their effects without sensation or volition" (Ref. 31, p. 93). These two men anticipated by a century the physiological research of Fechner ("unconscious sensations"), Wundt ("unconscious inferences"), Helmholtz, and others.

In Germany, Ernst Platner (1744-1818), professor of physiology at Leipzig, was influenced by the philosopher Leibniz, and maintained the presence of unconscious elements in thought and feeling (Ref. 15, Vol. II, p. 322).

In France, Pierre-Jean-Georges Cabanis (1757-1808) wrote of "*sensibilité sans sensation*" or "*impressions dont l'individu n'a nullement la conscience*."<sup>32a</sup> He formulated a hierarchical "level" theory of nervous action and a "destruction-reproduction" hypothesis, which were rediscovered by John Hughlings Jackson almost a century later.

\*Italics the present writer's.





For Cabanis, the spinal cord carried out reflex acts in response to stimulation. At a higher level, semiconscious and semi-integrated activities took place: This was the center for vital and instinctive faculties. At the uppermost level, in the brain cortex, complicated functions, such as thought and volition, were located.

In his *Coup d'oeil sur les Révolutions et sur la Réforme de la Médecine* (1804),<sup>32b and c</sup> he wrote: "Observe that youth, who haunted by a vague uneasiness, continually absorbed in reverie, and melted to tears by the slightest emotions, begins to find ideas in his imagination, and desires in his heart, which, before, were unknown" (Ref. 32c, p. 308). Here one sees an insight into the awakening of instinctual drives at puberty, and intimation of a knowledge of unconscious ideas and emotions. He wrote of "inert" or "unknown" ideas and passions.

François-Pierre-Gonthier Maine de Biran (1766-1824),<sup>33</sup> a contemporary of Cabanis, clearly distinguished levels of mental activity. Below consciousness, where intellect and reason held sway, he placed a stratum which was out of voluntary control, a region where passion reigned supreme. He described how the latter asserted itself in dreams and moments of inattention. Maine de Biran analyzed consciousness by comparing it to the center of a circle, from which unconscious processes radiated, becoming fainter as they receded from the center. This was an identical simplification to that which Paul Carus used in explaining what he called central (conscious) and peripheral (unconscious) soul life.<sup>34</sup>

In Germany, Friedrich Eduard Beneke (1798-1854) formulated his doctrine of "traces," which closely resembled the theory of Herbart, with which it was contemporaneous. No activity of the mind was ever completely lost. The disappearance of every idea from consciousness left a trace, which served as a basis for subsequently coming back into mind.<sup>35, 35</sup>

After the 1820's, the theory of unconscious mental action became widespread in psychology and medicine. One reason for this was an increased interest in hypnosis, which was due in large part to Alexis Bertrand, John Elliottson, James Esdaile, and particularly James Braid, who published his book *Neurypnology* in 1843. These men, and others of course, were responsible for the growth of crude animal magnetism into scientifically acceptable hypnosis, free of mystery and humbug. The research in hypnotism naturally led to the investigation on a scientific basis of unusual states



of consciousness such as trances, fugues, and automatic behavior, and to the mechanisms involved in the genesis of neuroses. Sleep, dreams, and somnambulism also came to merit more attention from physicians.

As representative, one may note the work of John Abercrombie (1781-1844)<sup>36</sup> and Robert Macnish (1802-1837).<sup>37</sup> Abercrombie, in his *Inquiries Concerning the Intellectual Powers* (1830), had much to say on association *without consciousness* (Ref. 36, p. 110). What had previously been wordily stated in philosophy, he elaborated into clear and concise medical diction.

Macnish, in discussing dreams, wrote: "When, however, one faculty [i. e., of mind] or more than one, bursts asunder the *bonds*\* which enthralled it, while its fellows continue chained in sleep, then visions ensue, and the imagination dwells in *that wide empire which separates the waking state from that of perfect sleep*\* . . . the imagination is at work, while the judgment is asleep; and thereby indulges in the maddest and most extravagant thoughts, free from the salutary check of the latter more sedate and judicious faculty" (Ref. 37, p. 52). One sees here an understanding of unconscious fantasy life, strong in emotional tone and short on intellectual control.

Toward the middle of the nineteenth century, the unconscious took on a neurological veneer which was in keeping with the somatic orientation of the day. Notable was the work of Thomas Laycock (1812-1876), who was physician to the York dispensary, and Wilhelm Griesinger (1798-1868), professor of mental science at Berlin. In the early 1840's they both developed the concept of "reflex activity" of the brain. Laycock<sup>38</sup> wrote on "reflex function of the brain," and also of the "substrata [i. e., ideagenic and kinetic]\*\* of psychical phenomena": ". . . these substrata may be persistent as a part of the organism, and continue to be manifested by acts long after the necessity for those acts, as conservative of the individual or race, has ceased . . . these substrata may be dormant for a lengthened period from the want of a reagent, and appear extinct, but will reappear so soon as the impressions adapted to their action are received by and conveyed along the afferent nerves" (p. 308). Griesinger<sup>39</sup> wrote of "psychic reflex action," which apparently was meant to describe the same sort of thing.

\*Italics the present writer's.

\*\*Present writer's comment.



This whole neurological approach culminated in the "unconscious cerebration" of the physiologist, William Benjamin Carpenter (1813-1885). In 1852, he wrote<sup>40</sup> of "unconscious storing up of impressions," which could only be brought to consciousness by the connecting link of associations (p. 783), and he included the emotional factor: ". . . it must not be left out of view that *emotional* states, or rather states which constitute emotions when we become conscious of them, may be developed by the same process . . ." etc. (p. 791).

One should mention Sir Benjamin Collins Brodie (1783-1862),<sup>41</sup> the great surgeon who was so interested in psychology—most unusual for a surgeon! This man carried out fundamental observations on the somatic symptoms of hysteria, and pointed out that the condition was not a result of observable pathological changes in the brain or spinal cord. He wrote: "mental operations of which we seem to be unconscious" (Ref. 41, p. IX), and ". . . as if there were in the mind a principle of order which operates without our being at the time conscious of it . . ." (p. 20).

The discussion would not be complete without reference to Henry Maudsley (1835-1918).<sup>42</sup> He had a very clear formulation of unconscious mental activity which included both ideation and emotionality. He explained everything on a neurophysiological basis.

In Maudsley's *Physiology and Pathology of Mind* (1867) we read: "It is a truth which cannot be too distinctly borne in mind, that consciousness is not co-extensive with mind. From its first moment of its independent existence the brain begins to assimilate impressions from without, and to re-act thereto in corresponding organic adaptations; this it does at first without consciousness, and this it continues to do unconsciously more or less throughout life. Thus it is that mental power is being organized before the super-vention of consciousness, and that the mind is subsequently regularly modified as a natural process without the intervention of consciousness. The preconscious action of the mind, as certain metaphysical psychologists in Germany have called it, and the unconscious action of the mind, which is now established beyond all rational doubt, are assuredly facts of which the most ardent psychologist must admit that self-consciousness can give us no account (p. 15). . . . Anything which has existed with any completeness in consciousness is preserved, after its disappearance therefrom, in the mind or brain, and may reappear in consciousness at some fu-



ture time. That which persists or is retained has been differently described as a residuum, or relic, or trace, or vestige or again as potential, or latent, or dormant idea; and it is on the existence of such residua that memory depends. Not only definite ideas, however, but all affections of the nervous system, feelings of pleasure and pain, desires, and even its outward reactions, thus leave behind them their residua, and lay the foundations of modes of thought, feeling and action . . ." (p. 15).

### H. AFTER 1850

It would be out of place to include Sigmund Freud's contributions to unconscious theory in a historical discussion, and the same may be said of Carl G. Jung's (the *collective* unconscious). However, in addition to the numerous authors discussed here at length, a large number of others have at some time or another, prior to or very soon after the turn of the present century, indicated in their writings that they were familiar with unconscious mind action. It might be interesting to list a few of them as follows in alphabetical order:

- |   |   |
|---|---|
| Ach, N.   | Gorton, D. A.   |
| Barrett, W. F.  | Grasset, J.   |
| Bascom, J.  | Helmholtz, H. L. F. (unconscious inference)   |
| Bastian, H. C.  | Hering, K. E. K.  |
| Bergson, H.   | Höfdding, H.  |
| Bernheim, H.  | Holland, H. (dislocated memory)   |
| Binet, A.   | Holmes, O. W.   |
| Bleuler, E.   | Ideler, C. W.   |
| Brœuer, J.  | Ingersoll, A. J.  |
| Brierre de Boismont, A. J. F.                                       | Jackson, J. H. (theory of levels)   |
| Brœchner, H.  | James, W. (subconscious incubation, extramarginal consciousness)                      |
| Butler, S. (unconscious memory)                                     | Janet, P. ( <i>idées fixes</i> , subconscious, secondary consciousness, dissociation) |
| Carlyle, T. (unknown deep)  | Jastrow, J.   |
| Carrière, M.  | Jung, C. G. (collective unconscious)  |
| Carus, P. (peripheral soul life, the unconscious)                   | Koch, J. L. A.  |
| Cobbe, F. P.  | Kretschmer, E. (sphaïra)  |
| Creighton, C.   | Lange, C. G.  |
| Dessoir, M.   | Lazarus, M.   |
| Faraday, M.   | Lewes, G. H.  |
| Fechner, G. T. (unconscious psychical processes, sensations, ideas) | Lotze, R. H.  |
| Feuchtersleben, E.  | Morgan, C. L. (infraconsciousness)  |
| Freud, S.   | Myers, F. W. H. (subliminal consciousness)  |
| Galton, F. (antechamber of consciousness, deeper strata)            |   |



Nietzsche, F.	Scott, W.
Page, C. W.	Sidis, B.
Perty, J. A. M.	Stout, G. F.
Porter, N.	Sully, J.
Prince, M. (co-conscious)	Tuke, D. H.
Ribot, T. A. (preconscious, unconscious)	White, T. G.
Richer, C. R.	Whittaker, T.
Richter, J. P. F.	Wundt, W. (unconscious inference, unconscious soul)
Schelling, F. W. J.	Zeller, A.
Schindler, A.	Zöllner, F.
Schofield, A. T.	

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## EDITORIAL COMMENT

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### CONCERNING A DUSTY ANSWER

One can be too "hot for certainties in this our life!" And some of us appear hot for a certainty that is not to be found in psychiatric, medical or any other science.

There are probably as many definitions of science as there are scientists. To Abraham Flexner, science may be "the severest effort capable of being made in the direction of purifying, extending and organizing knowledge." Sir William Dampier defines it as "ordered knowledge of natural phenomena and of the relations between them." Webster's *New International Dictionary* says in part that it is "accumulated and accepted knowledge which has been systematized and formulated with reference to the discovery of general truths or the operation of general laws"; and the dictionary goes on to cite Karl Pearson's remark that science "may be described as a classified index to the successive pages of sense impression which enables us readily to find what we want, but it in no wise accounts for the peculiar contents of this strange book of life."

We read in all this no use of the term "certainty" which is something one finds once in the dictionary, frequently in theology, and seldom or never in life. Knowledge is something else. Knowledge is not certainty but is acquaintanceship with the facts, as we conceive of the facts. (Whatever the objective truth may be, it must always be screened for man by man's concept of the facts.) The whole history of science has involved constant shifting in concepts of the facts. Early man had a respectable body of accumulated and accepted knowledge which he had systematized and formalized to a very great extent in his attempt to discover truths and determine the operation of natural laws. His efforts deserve to be called the beginning of science—as well as the beginning of religion, for the hypotheses he adopted to explain what he failed to understand developed into primitive religions all over the world, and ultimately into such advanced religious systems as those of India, ancient Greece and ancient Rome.

But early man's concepts of what he observed were faulty and his hypotheses childish. He observed the sun rise in the east and



set in the west; and he conceived that the sun moved across a solid firmament above the earth, or, as his understanding developed, in a circular orbit around it. He saw the stars, fixed in their pattern, night after night and year after year, turn nightly about the pole, and he conceived of them, too, as fixed lights set in a solid canopy.

We see in the sky largely what early man saw except that his north star was likely Vega, or maybe *alpha* Draconis, not necessarily our Polaris. But concepts about what we see have changed. Yet we make use of much of it for the same purpose and in very much the same way that our remote ancestors did. It would be stupidly untruthful to deny that they, like us, made scientific observations and employed them for scientific purposes.

The present comment is inspired by two scientific articles in the October 1952 issue of THE PSYCHIATRIC QUARTERLY, "Patterns of Research in Mental Hygiene" by Benjamin Pasamanick and "Some Recent Trends in Organized Psychiatry" by Daniel Blain, to the latter of which we are indebted for the definition of science cited from Abraham Flexner. Dr. Pasamanick, in a discussion much of which we applaud heartily and with some of which we agree without reservation, concludes that mental hygiene (and presumably psychiatry as a whole) "ought to try to find answers to questions for which definitive answers are possible. . . ." Dr. Blain says frankly, "I worry about myself sometimes because of constantly believing things of which I see no definite proof . . .," but he cites Flexner's stress on "observation, inference, verification, generalization" to justify his own belief that "if psychiatry, as part of medicine" will recognize the necessity to be both artistic and scientific and will work for the development of tools to measure observations and compare them, "we will proceed and make further advances."

Between restricting its principal endeavors to questions for which definitive answers are possible, and working for the development of tools for use in psychiatric fields where "definitive answers" or "definite proof" are not yet possible, we think psychiatry must choose the latter course if it is not to put a period to all its progress as a science. But to make clear what we are striving for, we think, first of all, we should endeavor to present some idea of what is a definite proof or definitive answer. In one application, we think, and in one of importance to this discussion, there is no



such thing as a definitive answer in a scientific sense to any question in science. That is, we can know nothing, or virtually nothing, with absolute certainty unless we also have knowledge of the ultimate—knowledge of the cause of causes. Neither our five senses nor our reason commands the ultimate or offers any prospect of ever commanding the ultimate. And if they could, if we could trace cause and event with certainty back to first cause, we should come to the difficulty again of the limitations of human concept, human comprehension.

Science can no longer turn to theology for a basis of certainty; the long histories of science and theology have demonstrated no necessary conflict but have equally demonstrated that though they stand on common ground in the service of God and man, they are not and cannot be interdependent. Theology finds its certainties in its own way; science must be content with an ultimate uncertainty, beyond which is an ultimate unknown. A necessity of science is readiness to admit new evidence, accept new facts, test new hypotheses, work in accordance with new theories. Robert Heinlein, who specializes in fiction of the hypothetical future, makes one of his young characters remark “. . . if the course we had in the history of science means anything at all, it means that scientists change their theories about as often as a snake changes his skin. . . .” Well, from our point of view, perhaps not quite so often.

But from any honest scientist's point of view, theories do and must change as information accumulates. Consider astronomy. Although the correct heliocentric theory of the “universe” had been suggested long before the time of Ptolemy, who lived in the second century of our own era, man did not yet have the optical instruments or the mathematical concepts to support it; and Ptolemy's quite wrong geocentric theory was good science in the light of his day. It appeared to conform, for example, to his own sound, scientific principle, that is, in general, that in seeking to explain phenomena, one should adopt the simplest explanation in accordance with the observed facts. And wrong as the Ptolomaic theory was, it served the world as a useful tool of science for more than 13 centuries—into the age of the great voyages of exploration.

Similarly, Newton's formulations of the laws of gravitation served man for two centuries and still serve him in ordinary calculations, although Einstein and others have long since proved



that they are not even approximations of what we now conceive to be the truth about the universe. A scientific law is, of course, not a law in the sense in which the word "law" is otherwise used. It is a descriptive statement of what we think happens in the world as we see it under given circumstances; or it may be a mathematical or other formula covering such a description. Any scientific law may be proved incorrect, and none is immutable. Lancelot Hogben, whose politics are to be deplored but whose scientific acumen is considerable, states the case in *Mathematics for the Million*: "A scientific law is an approximate truth, and can only be used with safety when we know the limits within which it works sufficiently well for our requirements." Mathematics itself, sometimes regarded as the "purest" of the scientific disciplines, is based fundamentally on a series of entirely human definitions and assumptions—definitions and assumptions existing only in the mind of the mathematician. And as the mathematician has applied his "pure" mathematics to "actual" problems, he has been forced to new definitions and assumptions. For instance, to describe and understand by measurement the physical phenomena and the processes of the world today, as we see them or think we see them, the mathematician has resorted, among many other things, to "drunk" or "imaginary" numbers which, according to the old definitions and assumptions, simply cannot exist.

This discourse is by way of illustrating that science has, or claims, no certainty at its very foundations. Space-time appears to be a continuum, but we are uncertain of its nature and utterly ignorant of its cause—or if it has a cause. The quantum theory has cast new light on the structure of the atom and has demonstrated the "uncertainty principle" at the same time: that is, that there is a limit to the precision with which scientists can observe nature.  $E=mc^2$  appears to describe approximately the process by which the uncounted suns of uncounted galaxies produce energy, and the atom and hydrogen bombs are experimental demonstrations of the formula. But this observation does not explain why. And it is not beyond the bounds of theoretical possibility that it is as wrong as the Ptolomaic, geocentric theory of the universe—a useful concept, one leading to scientific advance, perhaps incorrect on the basis of future evidence, but the best we can do at the time. We might believe we knew a little more if we could settle



the unified field problem; that is, agree with Einstein or others on the characteristics of a unified field or single background for all physical activity—but we still would not know why.

If the whole tremendous pyramid of science is thus built on a foundation of the unknown or the doubtful, it is difficult to produce a good reason for medicine or psychiatry or any other specialty to limit its inquiries simply because its particular foundation includes more of the same. We know a great deal about inorganic matter, meaning again by "know" that we are well acquainted with a great many facts as we conceive of the facts. We know, similarly, a great deal about life and about specific living organisms. But we do not know the connection—and from the rest of science we must presume there to be one—between life and lifelessness, organic and inorganic. We believe we know something about the conditions under which life appeared or was created; but we haven't succeeded in evoking its appearance or creation by duplicating those conditions; and we are not certain that conditions undreamed of on our planet and impossible to duplicate here might not also produce a phenomenon we would term life, though perhaps on a totally different basis than our own. We don't even know what life is; the dictionary calls it, among much verbiage, a quality or character which distinguishes the living from the inorganic or the living from the organic dead, and which is manifested by certain qualities such as metabolism, growth and reproduction. This is pure description in the sense that it depicts something we cannot understand in the way of tracing from inorganic cause to organic effect—as we can trace cause and effect in inorganic science. And we think it adds little or nothing to call life in more scientific terms a function. Yet the whole of medical science, with its manifold specialties, is devoted to the preservation, prolongation and improvement of this uncomprehended thing called life.

The medical specialty of psychiatry is separated from general medicine by a second gap between the known and the unknown. As far as science is concerned, mind has much the same relation to life and living matter as life itself has to inorganic matter. One presumes there is a connection; in fact, we know of no scientist who would not insist vigorously on the necessity of a connection; but we are ignorant of its mechanism and of the conditions under which it operates. The psychiatrist thinks of mind as something intangible in which thought and emotion originate or manifest



themselves; sometimes he finds it convenient to assume that mind is an organ of the body; or he may think of it as a function of the central nervous system; or he may—some do—think of mind and body as a full dichotomy, the body acting as host for the unrelated mind only during maintenance of certain bodily life-functions.

We know some of the aspects and capabilities of intellect, but not its derivation; we may know a little more—but only a little more—about the relation of emotion to bodily structure and function. But by and large, we cannot trace mental phenomena to their somatic expressions or origins. We once believed we could localize the physical expression of certain mental functions in the brain, as we can localize areas of the physical senses, such as those of sight and smell; but experience with lobotomy and topectomy, as well as with occasional lobectomy, suggests that some of our confidence may have been misplaced.

The nature of the mental function known as consciousness (particularly in the form of self-awareness) may illustrate the uncomprehended; it is difficult to define satisfactorily, difficult to relate to other mental content, and baffling when one seeks its somatic representation. We do not even know how closely consciousness and other "higher" human mental attributes are associated with the forebrain, or whether they are shared—and if so to what extent—by other participants in the earth's drama of life. The comparative psychologists give us no answer to this.

But if we do not know the cause of mind, or its origin, or all its somatic representations, we do know a great deal about the mind itself. The mind has been the object of study and speculation as long as the body; we suspect the first man, like infants or some psychotics, had difficulty in distinguishing among mind-body-environment phenomena. Early medicine derived from early magic; it probably was directed quite as often toward mental relief as bodily; general medicine and psychiatry have inherited time-tested empiric practices in the field of mind, including the placebo, hypnosis and suggestion.

We know something of the capacities of the human mind. We know that all artifacts from the first flint arrowhead to the contents of the Library of Congress are products of the human mind. We know that at least one science, and that of tremendous importance, pure mathematics, originated in and exists in the human mind—without regard to applications to anything known or imagined in



heaven or earth. And we know that the modern results of this science—to the layman, inconceivably abstruse mentation—have contributed vastly to the understanding of all the closer-to-earth sciences and to the creation of modern technicological civilization generally.

We also have a good deal of descriptive material—and descriptive material is the basis of much non-medical science also—about mental derangement, dating from early times. King Saul was plainly a melancholiac; the behavior of the great Nebuchadnezzar, if the testimony of his jaundiced Hebrew enemies can be trusted, is consistent with a modern diagnosis of schizophrenia. We have known the general patterns of derangement for thousands of years. With all this, it is admittedly true, as Pasamanick points out, that our clinical diagnoses show such lack of consistency and uniformity that—as compared from state to state; we might add, perhaps, even from hospital to hospital—they are unsuitable for epidemiologic studies. We do not think, however, that this deplorable nosological confusion is warrant for abandoning either empirically- or theoretically-established psychotherapeutic treatment, or for throwing up our hands in despair about the possibilities of research. Rather, we think, diagnosis is something for the American Psychiatric Association and the administrators of the federal and state mental hospital systems to get together on and straighten out—with private practice well represented. The observance of uniform but doubtful categories will certainly leave much to be desired; but the general observance of almost any definite categories whatever should assist the epidemiologist and should not interfere with research, which—contrary to some opinion—we think is in a presently promising state.

The great difficulty—and we wonder if it is not an emotional as well as an intellectual difficulty—in studying the mind, is that mind itself must observe and study mind. Mind cannot be seen, touched, tasted, heard or smelled: it must observe and correlate its observations by special sense of its own. (We are aware, of course, that it employs the bodily organs and senses for this purpose.) Mind seems less real to many persons than phenomena which are detectable by the senses. One cannot watch it, perform surgery on it, dose it with cathartics, or take its temperature. One can only gauge it by studying it with another mind.



We are very far from suggesting that desire for something more nearly tangible forms Pasamanick's thesis; we don't believe it for an instant, although from the point of view of epidemiology he would like to have something he can measure; and nobody can blame him. But we do think his argument will appeal to those who particularly desire to apprehend, with the five bodily senses, what they are doing—the miscalled realists. And we think there is always a temptation to evaluate the real but intangible as something less than the real but tangible, a temptation known to all medical people, who have progressed through dissecting rooms to practise physical, tangible medicine and surgery on physical, tangible, living persons. We think it would be a great disservice to psychiatry should such a trend become dominant or even spread.

General medicine has been forced to treat living beings without being able to establish what life is or how it originates. We do not think it astonishing if psychiatry has been forced, likewise, to treat mind without knowing what mind is or how it originates. And we do not see that the one procedure is any less scientific than the other.

The problem of life is one for which we doubt there will be a solution in the presently predictable future. So, likewise, is the problem of mind. We do not think we should give up the practice of medicine because there is an unknown factor at its base, an unknown step in the scientific structure of causality. And likewise, we think we should maintain the practice, and continue to investigate the theory, of psychotherapy.

We do not believe, either, that we should give up the search for causality between mind and its somatic background. We believe firmly on theoretical grounds and because of repeated demonstrations of unknown links, or mechanisms of causality—clinically and experimentally—that psyche and soma are different facets of the same thing. Freud, whose work gave impetus to practically all modern schools of psychodynamics, even to those which disagree most emphatically with him, believed in a somatic basis for psychic disorder. And psychiatrists generally certainly see every reason to assume that psychic disturbance has its somatic counterpart. The fact can be observed clinically and experimentally any day.

If we can determine the mechanism or mechanisms by which this psychosomatic interrelationship takes place, we certainly should



spare no effort which is even remotely likely to do so. And so we are in full agreement with such suggestions as that advanced by Pasamanick for a controlled study in some undernourished population of the earth to see what effects an adequate supplementary diet for pregnant women would have on the growth, development and behavior of their offspring. He reports one exceedingly interesting and significant study which points to the importance of inquiry along these lines—a study which revealed that a large sample of New Haven Negro infants examined in 1944 were (somewhat unexpectedly) found equal behaviorally and intellectually to comparable groups of white children and to the New Haven white children upon whom norms had been established. Since they were also equal physically, in contrast to the usual lower birth lengths and weight curves of Negro infants, it was hypothesized that improved nutrition of their parents during wartime and under rationing had something to do with their good mental performance.

Psychiatry has everything to gain from research which may establish such psychosomatic links, though in the instance cited, the connection seems to be between nutrition and intellect, rather than between any physical factor and any clearly established dynamic one. We are also—and it shouldn't be necessary, but probably is, to say so—thoroughly in favor of such investigations into genetics as Kallmann's twin studies; in favor of continued vigorous inquiry into the psychosomatic ramifications of shock, psychosurgery and other physical and surgical therapies; and in favor of such work as the endocrine research currently being done at Creedmoor by the Sacklers. We are in favor of these things, even though the establishment of relationship in one or more of them might still leave gaps to close. We have a fully established relationship between organic brain damage in such entities as syphilitic meningo-encephalitis and arteriosclerosis, and the personality damage reflected in general paresis and in the psychosis which accompanies arteriosclerosis. But we still have not the slightest idea of how electro-chemical action in a damaged brain is transmuted into psychotic reaction. And we see, still without understanding, a contrary process demonstrated in the shock therapies. We think that, beyond much doubt, knowledge of how and why these processes operate might cast a great light on spots now dark in the wide field of psychiatry.



But the point we are anxious to make is that we should not permit reaction against the seven and seventy jarring psychotherapeutic sects to drive us from the psychotherapeutic field to one in which, because we can see and touch the object of investigation, we fancy there is more certainty, more opportunity to find definitive answers. We do not see the field of psychotherapy as such a cloudy, obscure and turbulent place as do many of its critics. The various schools which have developed around psychoanalysis have much theoretical basis in common; and much of this common basis is well established theoretically and clinically. The quarrels about points of difference—some of them vital points, no doubt—have given an unwarranted impression to the uninitiated that a cellar-full of embittered tomcats are battling to the death in the dark. We think useful therapeutic endeavor and valuable research are being carried on despite—or perhaps because of the stimulation of—the caterwauling.

Group psychotherapy, begun experimentally and continued for empiric reasons, now has respectable theoretical bases and better than a respectable clinical record in patients benefited, or even cured. So also, with short psychotherapy, and such modalities as hypnotic treatment in private practice and institutions. We think a majority of practitioners today are convinced that they are giving greater help faster than a few decades ago.

The statistics of this sort of thing are difficult to obtain; for one thing, they would rest largely on highly individualistic clinical opinion; for another, the methods which reflect accurately hospital admissions and discharges are ill-adapted to cover the very different field of the psychotherapists in and out of institutions; perhaps new statistical techniques are needed, as well as a standardized and co-ordinated method—if one is possible—for reporting, for comparative purposes, material which is now generally covered by notes of clinical impressions. We think, for the sake of Pasamanick and many others, more effort should be made to collect and present material of use to the epidemiologist.

But, we repeat that, susceptible to statistical treatment or not, the field of psychotherapy seems to have attracted the great majority of private psychiatric practitioners and a respectable number of institutional ones; and we feel that at least as great hope for the future lies here as anywhere. It is true that the psychotherapist is not dealing with anything detectable to the five physi-



cal senses, but only to the mind. But the mind, we may tell ourselves again, is as real as any bodily function or bodily organ. And we think we should not lose heart to investigate it through absorption in the quest for definitive answers. The well-trained investigator of the mind has every chance to come up with as satisfactory an answer as many an investigator of the body—for body or mind or space-time continuum, each has its quota of unanswered, and at present unanswerable, questions, questions for which not only definitive answers but any answers at all are at present unobtainable.

George Meredith was thinking of life, not of science:

Ah, what a dusty answer gets the soul  
When hot for certainties in this our life!

But many a scientist has found his own dusty answer, if less final than Meredith's sepulchral one, at the end of his quest for scientific certainties. For in science there are few or no certainties; there are extreme probabilities, probabilities so strong that we may accept them for all practical purposes as certainties; we may refer to them in ordinary discourse as certainties; but they are not actual certainties. One's observations may be faulty or interpretation of what one observes dead wrong. And a futile search for Pasamanick's "definitive answers" or Blain's "definite proof" might well lead to the non-exploration of the most scientifically-profitable possibilities and probabilities. We have faith that psychiatry will not be dissuaded from exploration of every road open, by the lure of diverting research toward a promised but impossible end. We do not share what seem to be Pasamanick's pessimistic views about the worth of psychiatric inquiry in fields where "definitive answers" are not possible, nor Blain's worry because of belief in things without "definite proof." We do share Pasamanick's enthusiasm for more research in fields where answers to some age-old enigmas may be possible. And we emphatically share Blain's belief that we shall proceed and make further advances.

The mind is inaccessible to the physical senses but is perfectly accessible to study by mind itself. As a natural phenomenon, it is a legitimate object of scientific study. We could make good use of knowledge of its linkage to, or integration with, the somatic phenomena which are accessible to the physical senses. But we have abundant evidence that we can comprehend much about the mind,



understand much about its ills, benefit it materially by direct therapeutic treatment—without waiting to learn everything that can be learned about mind-body relationships. We have set our course toward this end; we have made gratifying progress on it; and we intend to follow it unremittingly as long as the promise is held forth of better mental health and lessened human misery by our efforts.



## BOOK REVIEWS

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**Sterioencephalotomy (Thalamotomy Plus Related Procedures) with Brain Atlas.** A Description of Apparatus and Techniques. By E. A. SPIEGEL and H. T. WYCIS. 176 pages including index. Cloth. Grune & Stratton. New York. 1952. Price \$8.00.

Spiegel and Wycis give a brief but detailed account of an apparatus and procedure used to produce localized subcortical brain lesions without the rather superfluous brain damage often produced by the usual methods employed in psychosurgery. Sterioencephalotomy, as presented here, appears to be rather too complicated to replace quickly prefrontal lobotomy of the more crude types, but seems to be ideally applicable to the destruction of brain nuclei or the interruption of brain pathways, in which instances an exactly located, sharply circumscribed lesion is highly desirable.

A noteworthy, if limited, stereotaxic atlas of the brain is also provided. Study of the atlas is facilitated by having the plates and their respective descriptions on facing pages, obviating the all too frequent necessity of turning pages back and forth in works of this sort.

**Mental Prodigies.** By FRED BARLOW. 256 pages including index. Cloth. Philosophical Library. New York. 1952. Price \$4.75.

The author of this book is a long-time student of calculating prodigies and prodigies in general. It is devoted chiefly to brief reports of the seemingly incredible mental mathematical feats of the famous calculators of the last two and one-half centuries. As is well-known, some of them were *idiots savants* and others had little or virtually no education. The author is an experienced "mentalist" and his interest is particularly directed to the methods employed by the more spectacular calculators—when the calculators themselves knew them. The non-mathematical reader, however, may find it almost as difficult to employ some of the methods as to comprehend the results achieved. Barlow has included a chapter on famous memorizers and devoted another to mental magic, in which he discusses "a few of the many arithmetical effects which, after some practice, may be performed mentally by anyone of average intelligence." (This reviewer thinks many readers may find reason here to question their possession of "average intelligence.")

This book is a collection of facts and of notes on techniques. There is a minimum of speculation as to mental dynamics or organization. This may make the work all the better for the student of intellectual, as opposed to emotional, abnormalities. He will not have to quarrel at the start with anybody's theories.



**Psychiatry and Catholicism.** By JAMES H. VANDERVELDT, O. F. M., Ph.D., and ROBERT P. ODENWALD, M. D., F. A. P. A. 422 pages. Cloth. McGraw-Hill. New York. 1952. Price \$6.00.

This reviewer predicts that there will be many varied reviews of this book. The variations will depend upon which side of the "fence" the reviewer happens to be on.

In his foreword, Archbishop O'Boyle states, "From the time of the beginning of modern psychiatry to the present there have been problems concerning its relationship to Christianity. Many of the opinions voiced have been extreme. For some psychiatry has supplanted Christianity. Others find no room in the Christian fold for psychiatry, which they consider necessarily heathen. Neither of these extreme positions is true and both are harmful. Hence there has been a long-felt need of a book that would present a scientifically sane integration of psychiatry and Christianity. . . . This is a book that can be read with the assurance that the reliable findings of modern psychiatry are here fully and accurately presented with no prejudice to the teachings of Christianity. Since truth is one, the valid teachings of psychiatry cannot fail to harmonize with Christian ethics. By brilliantly using this norm as their flail in the rich harvest of psychiatric research, the authors have competently winnowed the wheat from the chaff."

One can sincerely say that one wishes that all this were true. Perhaps for Archbishop O'Boyle this is true, but for others there will appear a doubtful feeling, a feeling that perhaps instead of unifying psychiatry and religion, this effort has, for some, created greater confusion. On several different pages of the book it is implied that a psychiatrist is not qualified to treat emotional problems (except psychoses) because he does not know theology but that the priest is well qualified to treat such illnesses because he knows theology and can learn psychiatry. It is also implied that many psychiatrists are not qualified to treat emotional illnesses properly because they are atheists. One tends to question this, since practically no person in this world can honestly say that he has no God, whatever His name may be; nor can he say that he does not feel the presence of some supernatural being within and about him. No person should be denied the right to interpret his God or His emotional presence as he sees fit. He must not be coerced to interpret Him in a set manner. In this reviewer's opinion, it has never been the intention of the psychiatrist to persuade a patient to become atheistic, because all psychiatrists recognize the extreme value of religion in the treatment of the emotionally ill. The most for which the psychiatrist could be criticized would be that he is often broad-minded about religion.



If this were not so, how could he treat not only the Protestant, but the Catholic, the Jew, and others of varied faiths?

The authors make their greatest attack against Freud and his psychology. They grant concessions to Jung, Adler, Adolf Meyer, Thomas Moore, Eric Fromm, Karen Horney and others, but do not quite agree with anyone. The authors refer to their own "psychagogical method" of therapy, because "analysis by itself is not sufficient to effect a change and should be supplemented by the method of re-education. For this method the term 'psychagogic' has been coined; as the education of children is called pedagogy, so the education of the mind may be termed psychagogy." The authors really refer to a re-education in a religious and moral sense.

"The Catholic Church condemns any psychological or psychiatric theory or practice that clashes with the dictates of objective morality. . . . If there is a conflict between psychiatric and objective ethics, the former must cede the issue. Why? Because ethics deals with one's moral health, and psychiatry with one's bodily or mental health; the moral health is the more important of the two. . . . It is no secret at all that the knowledge of Catholic morality among psychiatrists is not always very profound; hence, it is understandable that many of them try to avoid answering such questions. Yet, the patients want an answer. Therefore, instead of simply brushing aside such questions, it would be more beneficial to the patient for the psychiatrist to refer him to a priest. Here, then we have an example of how a fruitful cooperation could be established between the pastor and the psychiatrist. . . . In practice, the problem will come down to this: is the psychiatrist justified in imposing his philosophy of life? . . . The psychiatrist who, consciously or unconsciously, would impose upon his patients his own philosophy of life would trespass the limits of his competence. . . . In simple words, if the therapist really deserves the name of psychiatrist, he must be able, through analysis and observation, to penetrate into the patient's personality and guide him according to the potencies, ideals, and aspirations that he discovers in his patient's psyche, regardless of whether they are hidden in the depth of his unconscious or are well above the level of consciousness. . . . If the psychotherapist is able to strengthen and steady the 'voice of conscience,' he is doing his client the best possible service. . . ."

In addition, the authors suggest that no non-Catholic psychiatrist is qualified to treat a mentally ill Catholic patient.

Apparently this book was written for the purpose of discussing psychiatry and Catholicism but nearly one-half of it describes the psychoses and other mental deviations in a way similar to many psychiatric textbooks. This latter part of the book, therefore, could have been left unwritten, although it is well done.



**The Cardboard Giants.** By PAUL HACKETT. 309 pages. Cloth. Putnam. New York. 1952. Price \$3.50.

Paul Hackett was a cardboard giant; so were his fellows on the mental wards of a VA hospital. Cardboard giant is Paul's figure of speech for it, not his delusion. Paul had felt his world becoming unreal for a long time; he had served in the army and been diagnosed mentally ill; in post-war days, he came to feel that an evil Mind ruled the world, not a benevolent God, and the Mind's hatred was directed toward him and his family. So he went to a mental hospital where the Mind still pursued him.

*The Cardboard Giants* is his story of his life in, and emergence from, the hospital. The dust jacket misdescribes it as the "inspiring story of how psychiatry and religion worked together to return a man to mental health"—which is just what it isn't. The story is not uninspiring; and no doubt psychiatry and religion did work together—the author describes an understanding, helpful and tolerant psychiatrist and a gentle, helpful and understanding priest—but the tale of what they did for the patient's betterment, and of how they did it is not clearly told. One can only suppose that Paul himself attributes his recovery to their combined influence.

What this book is, is a patient's picture of his own mental state and of his fellow-patients and members of the staff of the hospital. It is a series of sketches, almost vignettes; it is clear; it seems objective; it is not fanatical; this reviewer detects no trace of the paranoid in it. It is a narrative which might almost have been told in the third person of a man's becoming progressively deranged, becoming hospitalized and becoming well again. It is also a series of clear and exceedingly interesting reports on a number of his fellow-patients.

The reviewer thinks this book is to be recommended in general to persons who could profit by better understanding of what the inside of a mental hospital is like and of what being a patient is like. It is splendid mental hygiene for this and other reasons; Paul's fellow-patients are believable, and not at all unlikable, suffering human beings; the doctors are human, if fallible; the hospital has its drawbacks as a vacation spot, but it is no collection of torture chambers; those who work in our hospitals will see in it how they appear to a patient—from poor to good contact. And the book is readable; even entertaining in spots; the story of Dr. Shepard, who wasn't a mental patient at all but who was transferred from a naval hospital to a VA mental ward by mistake, must be read to be believed. (His specialty is not one with which psychiatrists commonly have much contact; and his explanations and protestations were taken as part of his non-existent delusions.) Finally, the psychiatrist will want to read this book as an account—even if unusually lucid and well-polished—of a mental disorder by the patient. Such a document is always of value.



**Pharmacology in Clinical Practice.** By HARRY BECKMAN, M. D., director, department of pharmacology, Marquette University Schools of Medicine and Dentistry; consulting physician, Milwaukee County General Hospital and Columbia Hospital, Milwaukee, Wis. XX and 839 pages, including 152 figures, 48 tables, a compendium of drugs, bibliography and index. Cloth. Saunders. Philadelphia and London. 1952. Price \$12.50.

*Treatment in General Practice*, known in its many editions as "the Beckman," is such a world-wide accepted standard textbook that it does not require any introduction or recommendation. But the present book by the distinguished author is a completely new, differently organized and originally conceived book that deserves special consideration. It will replace the former "Beckman" and will gain new friends and admirers. In its very individual and attractive style, it will guide the reader "in terms of specific diseases and symptoms and not of anatomical groupings of organs or chemical groupings of drugs" to the requirements of treatment.

It would be futile to review the general content of this encyclopedic textbook. But to give some of the flavor which it gives to the reader, it may be permitted in this place to cite the author's position on drug therapy in regard to psychiatry and neurology in his own words:

"At least half of your patients will have an emotionally determined or perpetuated disorder and should have psychiatric attention. But they cannot all be seen and carefully studied by psychiatrists, and so, if you are not a psychiatrist yourself you will have to cope with the situation as best you can. It would be fine if you could turn to these pages with confidence that you would learn of many specific or at least helpful drugs, but unfortunately that is not the case. Psychiatry and psychiatric concepts have begun to affect all medical branches. The psychiatrists are searching, too, among the other medical disciplines for aid and enlightenment regarding their own diagnoses and therapeutic approaches. It is too bad that pharmacology has offered so little as yet. The trouble is that the mechanisms of nervous actions are poorly understood and the application of scientific methods to the psychologic processes is extremely difficult.

"As for neurology, well, the poor neurologist cannot even earn a living in the practice of his specialty alone. He must function as a psychiatrist too, or do his neurology as a side line in another specialty. There are two reasons for this, and we in pharmacology are to blame for only one. In the first place, it is traditional that the neurologist must stop at diagnosis—someone else must treat his cases. In the second place, if he were to treat his own diagnosed maladies he would have little to work with. Pharmacology has simply not provided the drugs with which good 'specific' results can be obtained.



"Space limitations will permit me to deal pharmacologically with only a portion of the entities that are of neuropsychiatric nature. Most of the drugs mentioned will have had major presentation in the book and you are requested to consult the Index for information about them not supplied in the present chapter.

"Psychoneurosis: Here is our greatest pharmacologic failure in any field of medicine. A drug that would 'straighten out' the psychoneurotic individual would be a god-send to patient and doctor alike. But I do not know, perhaps the development of such a drug would not be so fine. It would at once cut down the necessity for so many doctors, and we all like to be doctors. There is no need for present worry, however, since we do not have the drug."

There is no other textbook of pharmacology which equals or surpasses this book as far as completeness, competent information, sound clinical approach and universality is concerned. It is a pathological physiology in a grand style. Many excellent illustrations, an up-to-date compendium of drugs and a carefully detailed index of 69 pages enhance its value.

**The Transmission of Nerve Impulses at Neuroeffector Junctions and Peripheral Synapses.** By ARTURO ROSENBLUETH, head of the department of physiology and pharmacology of the Instituto Nacional de Cardiologia de México. Cloth. XIV and 325 pages including preface, introduction, 720 references, author index and subject index; with 98 figures and 14 tables. Technology Press of Massachusetts Institute of Technology and John Wiley & Sons, Inc. New York. 1950. Price \$6.00.

This new book by a distinguished author is the first comprehensive report on present-day knowledge, and on still "existing unsolved problems of the chemical transmissions at the junctions of motor nerves with striated muscles and at the synapses in autonomic ganglia." The theories of cholinergic and adrenergic stimulation find their epistemologic and experimental foundation. "It could not yet disclose if chemical transmission is the only mode of transmission. No generally accepted opinion can be given on the problem how the mediators, liberated by autonomic nerve impulses, act and how the inhibitory responses function."

The more complex and debatable problem of transmission in peripheral synapses is widely discussed in the second part of the book. The author stretches mainly his arguments of chemical transmission although he points out that many authorities believe in the prevalence of electric transmission at peripheral synapses.

This book with its careful bibliography and indices constitutes an indispensable text and reference book for the expert in cybernetics and neurophysiology.



**The Spire.** By GERALD WARNER BRACE. 380 pages. Cloth. Norton. New York. 1952. Price \$3.50.

If the author of *The Spire* hasn't created a great novel he has at least offered his readers something to think about in devising a college professor who behaves both wisely and well in an atmosphere of embedded prejudice and suspicion.

The setting is a small New England college where the battle rages between Henry Gaunt's integrity and the traditional academic protocol of his fellow faculty members.

Perhaps New England literature has taught us to expect a frustrated spinster, a half-witted recluse, town gossips and fine minds gone to seed. They are all here. But it is to the credit of the author that he is able to make them real and extricate them from universal dilemmas with solutions that never descend to coincidence. No ultimate happiness is predicted, but one comes to feel that a wise man who can maintain his emotional balance may hope to make some impact on the bigotry and prejudice that beset us all.

**Symposium on the Healthy Personality.** Transactions of Special Meetings of Conference on Infancy and Childhood, June 8-9 and July 3-4, New York, 1950. Milton J. E. Senn, M. D., editor. 298 pages. Cloth. Macy Foundation. New York. 1950. Price \$2.50.

This book is published on a cost basis so that investigators and workers in the field of child health and child welfare who were unable to attend the sessions can become acquainted with the interesting reports and stimulating discussions which took place at the meeting of the fact-finding committee of the Midcentury White House Conference on children and growth.

The subjects presented for discussion follow.

"Growth and Crisis of the Healthy Personality" was the subject of Erik H. Erikson who spoke of eight criteria of the healthy personality, commencing with trust in infancy and culminating in integrity at adulthood. The social radii of these criteria at different growth levels are taken up as are the crises which accompany each stage. The paper is primarily psychoanalytically oriented. However, the discussions presented by other members make the over-all picture more eclectic.

The second paper, "Constitutional and Parental Factors," was prepared by M. F. Ashley Montagu. Three factors are considered: "(1) What are the inherited genetic potentialities (the genotype) of the organism? (2) How are these influenced by the internal and external environmental factors during prenatal life? (3) What role does each of these factors play in influencing the subsequent physical and mental health of infant and child?" In considering these questions, the fetal "environment" is discussed at some length in terms of the transmission of emotion from the mother by the



neuro-humoral system; the effects of physical and nutritional stimuli; the results of maternal age; sensitization and dysfunctioning; as well as many other factors.

The third paper, "Toward a Social Psychology of Mental Health," by Marie Jahoda, was oriented around the import of community influences on the mental health of an individual. A worth-while and rounding-out discussion, complementing the two previous papers, revolved around the Kurt Lewin field theory that behavior is always a function both of personality and its environment.

The conclusions of these papers and their concurrent discussions are rich and manifold and cannot be summarized in a few words, but the reviewer highly recommends this book to all interested in human behavior, the personality and mental hygiene.

**Psychotherapy of Psychosis.** By GUSTAV BYCHOWSKI, M. D., assistant clinical professor of psychiatry, New York University College of Medicine. 328 pages including notes and references and index. Cloth. Grune & Stratton. New York. 1952. Price \$5.75.

After reading this book one does not really know to whom it is addressed. It is a compilation of references and citations of the European schools of psychiatry presented in a rather unorganized manner, and it represents in its unsystematic verbosity an unsatisfactory review of an arbitrary eclecticist. It seems as if the author himself is struggling with clear terminology and the meaning of the no-doubt-industriously studied works of Kraepelin and Bleuler, Freud and Ferenczi, Husserl and Minkowski—to cite only a few. The author states that he "could show by way of analysis of the stream of thought that the waves of energy originating in the brain of schizophrenics have special characteristics." He further states, quoting from his own previous publications, that he "could show that the thought-products of schizophrenia are characterized by a weakening of a factor which we might call temporal order." But "after all, no matter what theory one holds regarding the initial and the essential disturbance in schizophrenia, still nobody could deny that schizophrenics think, speak, perceive and write with their brains like anybody else." (Compare Franz Alexander: "His [the psychotic's] thought-processes and feelings are so different from those of healthy persons that common sense cannot grasp them.") It is not doubted that the intention of this publication is a worthy one. Each of the 34 chapters may be an industriously prepared lecture in which many statements may be made which sound differently when presented under the stimulating atmosphere of the give and take of an interested student audience. But to write a textbook is a different story. It requires planning, organization, systematization and clarification on a high and matured level. This well-meant book offers none of them.



**Cybernetics.** Circular Causal and Feedback Mechanisms in Biological and Social Systems. Transactions of the Eighth Conference, March 15-16, 1951, New York, N. Y. Heinz von Foerster, department of electrical engineering, University of Illinois, editor. Margaret Mead, American Museum of Natural History, and Hans Lukas Teuber, department of neurology, New York University College of Medicine, assistant editors. XX and 240 pages, including Josiah Macy, Jr. Foundation Conference Program (by Frank Fremont-Smith, M. D., medical director), a note by the editors, Appendix I, the nomenclature of information theory by Donald M. MacKay, King's College, University of London; and Appendix II, references. Cloth. Macy Foundation. New York. 1952. Price \$4.00.

This book cannot be reviewed because "this is," in the words of the editors, "not a book in the usual sense, not the well rounded transcript of a symposium."

But no one who is himself in the front line of scientific research, no one who wants, at least, to keep his finger on the pulse of the indefatigable heart of scientific progress, and no one whose mind is receptive enough to feel the thrill of being present at the birth and development of new spheres of knowledge should miss studying this volume thoroughly. Cybernetics—so-called by Norbert Wiener, the great mathematician of M. I. T.—is the science of transmission and communication; and this present document is "an account which attempts to capture a fragment of the group interchange in all its evanescence, because it represents to us one of the few concerted efforts at interdisciplinary communication."

The reading of this volume gives an unusual stimulation because of the mainly extemporaneously-presented subjects and the unprepared discussions on the highest level. It brings the reader into the presence of creative research. Topics discussed include: communication patterns in problem-solving groups; meaning of language as communication between men; hypnosis as communication between sane and insane; communication between animals; presentation of a maze-solving machine; in search of basic symbols. But these cannot show the extent and the universality of the problems stressed. But they may—the reviewer hopes—stimulate the reader of these lines to become interested and to read these transactions.

**The Superego.** By EDMUND BERGLER, M. D. 367 pages. Cloth. Grune & Stratton. New York. 1952. Price \$6.75.

*The Superego* is a thought-stimulating, and emotion-provoking, study of the unconscious conscience as the key to the theory and therapy of neurosis. If the reader can overcome the tricks his own super-ego will play on him as he reads this exposition, he will have a better understanding of so-called normal as well as of neurotic behavior problems.



While Bergler's previous books have been written for both the general practitioner and the specialist, *The Superego* seems to have been written with the analyst primarily in mind, although it, too, is written with the same simplicity of style and phraseology, and with the good sense of humor, typical of Bergler's approach to the results of man's attempt at a "defense against the defense."

*The Basic Neurosis* and *The Battle of the Conscience* set forth Bergler's theories, with supporting clinical evidence derived from 25 years of psycho-analytic psychiatric experience. *Money and Emotional Conflicts* and *Neurotic Counterfeit Sex* described in detail some of the many disguises the basic neurosis—psychic masochism based on oral regression—assumes. In this latest contribution, the blame is placed on the super-ego as the instigator of these problems. Man uses 50 per cent of his productive energy in his efforts to defend himself against his internal conflicts, Bergler states.

The foreword provides an excellent background of Freud's thoughts and writings in the last years of his life on the role of the unconscious conscience. The first two chapters give details of the structure of the super-ego. This is followed by the psychic microscopy of 50 human reactions, selected at random: Ordinary daily occurrences and attitudes are explored, such as cynicism, pessimism and optimism; the matter of being a wit; patience and impatience; silence and hypertalkativeness; over-drinking and chain-smoking; and reactions on waking up in the morning. The chapter on "Dreams and Inner Conscience" delineates why Bergler and Dr. Ludwig Jekels in 1933 came to the conviction that the formulation "... every dream represents an unconscious wish-fulfillment" should be enlarged to "... every dream represents an unconscious wish-fulfillment and a defense against a reproach of the superego."

"Are Parents or Inner Conscience to Blame for the Neuroses of Children" is a chapter which will be read with relief, tinged with despair, by those who try in the middle of the twentieth century to do what is "right" for their children.

Bergler concludes "... every human being—in quantitatively different degree—becomes 'addicted' to psychic masochism . . . But knowledge does help—somewhat . . . (for it) also is the potential power to accept reality without much ado and without whimpering of the 'I feel sorry for myself' variety."

**Anstaltskinder (Nursery-Children).** By D. BURLINGHAM and A. FREUD. 138 pages. Cloth. Imago Publishing Co. London. 1950. Price 8/-.

The booklet was first published in English in 1943; this German translation is now available. The topic is the case for and against residential nurseries. The material is interesting; the conclusions are marred by lack of precise differentiation between pre-Oedipal and Oedipal mother, and by not stressing the importance of masochistic components.



**The Thyroid.** By THOMAS HODGE MCGAVACK, B. A., M. D., F. A. C. P., professor of clinical medicine, New York Medical College; director of New York Medical College, Metropolitan Hospital Research Unit. With a Section on Surgery by James Winfield, B. A., M. D., F. A. C. S., professor and director of surgery, New York Medical College, and Walter L. Mersheimer, B. S., M. D., F. A. C. S., associate professor of surgery, New York Medical College; and a section on history by Dorothy B. Spear, Ph.B., librarian, and Thomas Hodge McGavack. Cloth. 646 pages including 22 tables, 72 figures, bibliography and index. Mosby. St. Louis. 1951. Price \$13.50.

Very few organs of the body have stimulated more research work than the thyroid gland. Superseded only by the antepituitary, "the conductor of the symphony of the endocrine glands," the thyroid gland represents about the position of the first violins. Every year, there appears in the literature an overwhelming amount of detailed individual material—to keep track of which is nearly impossible for the non-specialist in the field. Dr. McGavack and his co-workers have undertaken the tremendous job of giving a comprehensive review of the present state of our knowledge of the physiology and pathology of the thyroid in a single-volume monograph. Very few authors are as competent for this task as Dr. McGavack, who himself has contributed so much to present knowledge.

The book is organized in four sections: Section I on history; Section II on anatomical, chemical and physiological considerations; Section III, the largest part, on morbid states; and Section IV on surgical considerations. The authors have done a great service in offering this monograph. Its very well-written content is supplemented by good illustrations, many tables, an international bibliography and a good, clear index. This book can be recommended highly as a text and for reference.

**The Treatment of Injuries to the Nervous System.** By DONALD MUNRO, M. D. 284 pages including index. Cloth. Saunders. Philadelphia. 1952.

Here is an excellent, concise guide to the do's and don'ts of treating nervous system injuries of all kinds. Its numerous tables make the location of diagnostic and therapeutic measures both convenient and rapid. Emergency and definitive procedures are given equal, and thus correct, emphasis, and the important problem of rehabilitation of paralyzed patients is not overlooked. Occasionally, practicality suffers for the sake of technical and theoretical accuracy. Nevertheless, this book should prove valuable to less specialized practitioners, who, from time to time, must assume responsibility for persons suffering from traumatic lesions of the nervous system.



**The Meaning and Practice of Psychotherapy.** By V. E. FISHER, Ph.D., psychologist and psychotherapist. XV and 411 pages including preface, introduction, selected readings, glossary and index. Cloth. Macmillan. New York. 1950. Price \$5.00.

This book of 411 pages on the "meaning and practice of psychotherapy" starts with 43 pages entitled "a general orientation concerning approach and procedure." This section, Part I of the book, appears rather inadequate for many reasons and therefore misleading. Three hundred and fifty more pages contain records of treatments. This latter material is subdivided in three parts: Part II, some psychotic and closely related disorders; Part III, psychoneurotic reactions; Part IV, some maladjustive psychosocial tendencies and reactions. This classification and the terminology used show a rather incongruous systematization, considering the title and possible intention of the book. The chapters containing case records differ in their quality and acceptability.

It is not quite clear into what gap this book fits. At the best, it may serve to arouse the critical faculties of a well-organized and systematically-trained psychologist or psychiatrist. As a textbook, it is inadequate; as an introduction for the student, it appears too unsystematical.

**Statement on Race.** New Revised Edition. By ASHLEY MONTAGU. 182 pages including index. Cloth. Schuman. New York. 1951. Price \$2.75.

This is a second edition of the famous *Statement on Race* drawn up for UNESCO by a group of the world's leading social scientists. This edition includes, for the first time, a statement on the nature of race and race differences by a group of physical anthropologists. The group drafting the original statement was made up largely of social scientists; there were naturally some criticisms; and the physical anthropologists now present their own point of view, stressing the biological aspects. So far as the general reader is concerned, the statement of the physical anthropologists is in substantial agreement on every important point with the original statement and should reinforce the authority of the latter. Social scientists in general will agree with the principal points of both.

This volume is an important weapon for the armamentarium of any social scientist, including the psychiatrist, who may be faced with a problem of prejudice involving a racial question. It is an excellent basic text for elementary instruction and a fine basic statement for general reading. As presented here, the UNESCO statement is first given in full; then it is reprinted by paragraphs, with Montagu's discussion of each paragraph. The fighter for the cause of truth and tolerance can do no better than wish this volume the widest possible circulation.



**Die Execution des Typus und andere kulturpsychopathologische Phaenomene.** (The Execution of the Type and Other Psychopathologic Phenomena of Culture.) By Professor Dr. W. WAGNER. 135 pages. Thieme. Stuttgart. 1951. Price DM 15, 60.

The foreword informs us that the problems of psychopathology of culture are approached from the psychiatric viewpoint. The text proves that the promise is so little kept that one has to reread the foreword to ascertain that a psychiatric promise was made in the first place. The book is the worst example of circumlocution this reviewer has encountered in a long time. What the author wishes to convey remains a mystery. As far as one can make head or tail of his words, he seems to reject typology, and excels in highly ambiguous statements, not even the descriptive psychiatric viewpoint is represented; it seems superfluous to state that unconscious mechanisms are not mentioned at all. At one point, the author exclaims: "Our position as cultural psychopathologists is that of despair (*ist zum Verzweifeln*). We never learn enough of human nature." Quite true: By avoiding unconscious mechanisms, ignorance of man's nature is perpetuated.

**It Takes All Kinds.** By MAURICE ZOLOTOW. 304 pages. Cloth. Random House. New York. 1952. Price \$3.00.

Maurice Zolotow likes to write about people whom he considers eccentrics. The present volume is a collection of sketches of 11 contemporaries, some of whom are of psychological or psychiatric interest. He devotes 60 pages to Dunninger, whose claim to extrasensory powers of perception has been widely publicized. He leaves the reader to form his own conclusions, of which a reasonable one might be that Dunninger does have some of the faculties he claims but that he lays claim to much else that he does not possess. This is a phenomenon not at all unknown in psychical research circles.

The other characters all have their points of interest. The author makes, however, what may be considered a regrettable attempt to trace their eccentricities to childhood circumstances. One suspects that he may have hit upon truth in some instances or at least upon partial truth, but the evidence is not convincing. This reviewer thought that Zolotow was writing in terms of Adlerian psychology until he came to the final chapter, "Acknowledgment," in which the author says, "A great deal of thinking that has shaped my analysis of the persons in this book reflects the ideas of the late Harry Stack Sullivan." The reflection is a surface one, and the reader might do well not to take the psychodynamics seriously; but *It Takes All Kinds* is, for pure entertainment values, well worth reading.



**Psychiatry and Medicine.** An Introduction to Personalized Medicine.

By LESLIE A. OSBORN, M. D. 490 pages. Cloth. McGraw-Hill. New York. 1952. Price \$7.50.

The reviewer of this book was well acquainted with the author when the latter was a general practitioner of medicine. In those days, Dr. Osborn seemed particularly interested in psychiatry and was in attendance at all psychiatric meetings. He was always a good speaker, and his discussions were always very well expressed. He continues to show such abilities in what, the reviewer believes, is his first book. As a whole, the book is extremely good, well organized and scholarly. It is apparently based upon lectures which the author gave during his teaching of medical students, psychology students, social workers and nurses. It is a book which all teachers of such groups can use in helping them to prepare their own lectures.

The reviewer gains the impression that, in this book, Dr. Osborn is reviewing and recording a method of learning the basic principles of psychiatry as he got to know them when his interests changed from general medicine to psychiatry. Furthermore, as stated on the book jacket, the book "... presents one physician's integrated concept rather than presenting a number of points of view sufficiently at variance to confuse the student who is trying to grasp the subject as a whole."

**The Valiant Coward.** By Y. ESTHER LIVINGSTON. 310 pages. Cloth. Dorrance & Co. Philadelphia. 1950. Price \$2.50.

Here is a badly written novel with an interesting plot: A young boy witnesses the mistreatment of a horse by an elderly neighbor, and throws a stone in his fury; the man collapses and dies; the boy considers himself a murderer. In reality, the death was caused by a kick of the horse; the facts become known to the stone-thrower many years later. In the meantime, his whole life becomes one great penance. De Maupassant once wrote a story of a neeklace where a similar theme is ironically, and not tragically, elaborated. Otherwise, there is little to recommend the book; the psychological implications are omitted, with exception of the guilt-theme.

**He, the Father.** By FRANK MIAKAR. 313 pages. Cloth. Harper. New York. 1950. Price \$3.00.

This is a novel about Slovenian immigrants in this country, centering around a masochistic couple. The author seems to have some superficial knowledge of the Oedipus complex, and he makes the most of it. As he is a gifted writer, a good deal of pre-Oedipal material is included, though he obviously does not know how to handle it. Despite some confusion in the book, it is worth perusing.



**Progress in Neurology and Psychiatry.** An Annual Review. Volume VII. E. A. Spiegel, M. D., editor. 592 pages. Cloth. Grune & Stratton. New York. 1952. Price \$10.00.

This annual review continues to be of high quality. Those who have previous volumes will want this one, too, and those who have not previously had the review and need a reference book in these subjects should add this one to their libraries. The reviews are very brief but they cover enough to inform the reader about the articles summarized so that if he wants more information the numerous references can tell him where to find it.

This year, there are the usual sections on basic sciences, neurology, neurosurgery and psychiatry, but new chapters on pediatric neurology, on genetics, on the neurosyphilises and on criminal psychiatry have been added.

**The Contributions of Harry Stack Sullivan.** A Symposium on Interpersonal Theory in Psychiatry and Social Science. Patrick Mullahy, editor. 228 pages. Cloth. Hermitage. New York. 1952. Price \$3.50.

In some psychiatrists' minds, there is gradually developing a trend toward a psychiatry that is more understandable to the patient. The psychiatrist must know the dynamics and mechanics by which mental illnesses arise but explaining the mechanics to a mentally-ill person does not often produce results therapeutically. It is because of this psychiatric viewpoint that this book is of importance at present. It is a review of the interpersonal psychiatry of Dr. Sullivan by men who knew and understood him. It gives a clearer picture to those who have failed to understand just what Dr. Sullivan meant. It brings to light many of his unpublished ideas. It reviews all of his ideas relative to theory, to clinical application and to sociological values.

**The Clinically Important Reflexes.** By Dr. med. FRIEDRICH WILHELM BRONISCH, instructor, research assistant, Psychiatric and Neurologic Clinic, University of Heidelberg. Revised and enlarged by Clemens E. Benda, M. D. 88 pages including bibliography, index and 49 large didactic illustrations. Cloth. First American edition. Grune & Stratton. New York. 1952. Price \$4.75.

Excellent service is done by Dr. Clemens E. Benda in offering an English translation of Bronisch's book on clinically important reflexes. This well-written manual, enlarged and revised, is a very useful and comprehensive guide through the theory and practice of the neurological examination, limited to the application of the accepted and important reflexes. The clear presentation enhanced by excellent schematic drawings can become a very useful pocket manual for the general practitioner as well as for the neuropsychiatric student and intern.



**Man and His Gods.** By HOMER W. SMITH. 501 pages including index. Cloth. Little, Brown. Boston. 1952. Price \$5.00.

Albert Einstein, in a brief foreword to *Man and His Gods*, calls the book "a broadly conceived attempt to portray man's fear-induced animistic and mystic ideas." The reader will find it a reasonably good elementary text of comparative religion, containing a good deal of valuable material. The orthodox member, of whatever sect, will not like it. Professor Smith's point of view, as he states in the epilogue, is: "As a fallen angel, man would be ludicrous. As an intelligent animal he has reason to be proud. . . ." Man, of all creatures, says the author, "alone can see himself and his world in width and depth. He alone can choose out of his vision of the present and the past his future course."

Aside from the author's point of view, the text part of his book would be vastly improved by references and bibliography. One presumes they were omitted in an effort to compress, but the author devotes more than 40 pages to "the story of this book"—and of himself. He had difficulties in finding a publisher, and the subject is of some interest, but the reviewer would have preferred a bibliography nevertheless. The acknowledgments in the text and the explanatory acknowledgments in this final chapter are not arranged for easy reference or as ready guides for further reading. The volume therefore lacks authority but may be recommended as a general guide to a difficult subject to persons who will not take offense at some of the author's downright personal opinions.

**This Is Your World.** By H. A. WILMER. 152 pages. Cloth. Thomas. Springfield, Ill. 1952. Price \$5.50.

Dr. Wilmer's book attempts to convey to professional workers some of the emotional problems encountered in chronically ill tubercular patients. It is a guide for group therapy; it contains a long poem—a ballad—and 16 dialogues concerning parent-child relationships. The intentions are good, the drawings of the author interesting; what is missing is one of the decisive emotional conflicts: the masochistic misuse of (and contribution to) the illness.

**Zero.** By ROBERT PAYNE. 262 pages. Cloth. John Day Co. New York. 1950. Price \$3.50.

*Zero* is a valuable and extensive, descriptive history of nihilistic terrorism, starting with Nechayev's *The Revolutionary Catechism*, tracing the influence of the theory of total destruction to Nechayev's pupils, Hitler and Lenin. The compilation of material is impressive; the weak point of the book is lack of a psychological explanation of the nihilist's mental aberration.



**The Infirmities of Genius.** By Dr. W. R. BETT. 192 pages including index. Cloth. Philosophical Library. New York. 1952. Price \$4.75.

*The Infirmities of Genius* is a series of sketches of 15 of the literary great about whom the author remarks that "the medical diagnosis of a man long dead is always difficult." He notes that he is nevertheless presenting his essays to the general public despite their speculative content because he believes that "an intimate and sympathetic knowledge of an author's medical or psychiatric case-history will enable the reader to appreciate or enjoy his works all the more." The aim is to be applauded; and the result is a volume which may be of some interest to persons—if such there are—who are not aware that many of the great had mental infirmities. It will not appeal, however, to either the literarily or medically sophisticated.

Lord Byron, for instance, is discussed as an instance of "lameness and genius." But Byron's psychopathic behavior is treated most sketchily. There is no discussion whatever of Byron's reputed incest with his half-sister; and his relationship with Claire Clairmont is mentioned without a note that she had an illegitimate child by him. The sometimes prudish Encyclopaedia Britannica, which dismisses (as of 1947) the *cause célèbre* of Oscar Wilde by noting that he was sentenced "under the Criminal Law Amendment Act," is much more informative about Byron's psychopathology than is Dr. Bett. Similarly, Walt Whitman is described in Bett's chapter heading as an "invert," but the discussion is vague, oblique and inconclusive. One can deduce the author's opinion only from the chapter heading.

Dr Bett has done stimulating and informative writing elsewhere on the subject. In an introductory note to the present volume, he states he has rewritten for it some articles, previously published in a scientific journal, with their "medical 'jargon' discarded." It is both reasonable and charitable to suppose that considerable bowdlerizing was done at the same time, a procedure which—advisable or not for readers in Great Britain where the book was printed—has damaged the work irreparably for scientific, literary or general reading in America.

**Attaining Manhood.** A Doctor Talks to Boys About Sex.

**Attaining Womanhood.** A Doctor Talks to Girls About Sex. By GEORGE W. CORNER, M. D. 92 and 107 pages respectively. Cloth. Second editions. Harper. New York. 1952. Price \$1.50 each.

These companion books should be on the shelves of every public library. The books are well organized, clear, straightforward, non-technical in most respects and with accurate illustrations. Youngsters of today are asking for and are entitled to frank advice. Too many parents fail to extricate sex from an atmosphere of mystery and badness. These books describe not only the biology of sex but also the psychology of sex.



**Speech Training.** By A. MUSGRAVE HORNER. 176 pages. Cloth. Philosophical Library. New York. 1952. Price \$3.75.

The author points out that since all speech is acquired by imitation, it is, therefore, unwise to be dogmatic about the best way to teach clear and intelligible speaking. He has provided here what he describes as "a collection of information indispensable to the serious student," and he would seem to imply that he may not know all that is to be known on the subject—a reasonable outlook, for in the matter of breathing, alone, there are many schools of thought. The author's views are well-reasoned and appear sound psychologically, but there is a dry, as well as physiological matter-of-fact presentation which will not appeal to many modern teachers. It should be mentioned that the book has excellent diagrams which many should find useful.

**Understanding Heredity.** By RICHARD B. GOLDSCHMIDT. 228 pages including index. Cloth. John Wiley & Sons, Inc. New York. 1952. Price \$3.75.

The author of this book expresses the belief that generally available books on genetics are too advanced and contain too much specialized material "for a large number of students who do not intend to specialize in biology." This book is intended for such students. It is elementary. The specialist will find condensations, generalizations and omissions. But this reviewer thinks it is admirably suited for its stated purpose. In the discussion of human genetics there are pleasing reticence and conservatism where the inheritance of mental characteristics is concerned. This book is adapted for such purposes as a school of nursing text or for reading for information by lay persons in general. There is an adequate glossary and an index sufficient for general reference purposes.

**Medical Biographies.** By PHILIP MARSHALL DALE, M. D. 259 pages. Cloth. University of Oklahoma Press. Norman. 1952. Price \$4.00.

Dr. Dale presents brief notes on the medical histories of 33 famous persons, ranging from Gautama Buddha to Grover Cleveland. It is a useful summary of material taken from generally accepted sources, and is a book which is both interesting and likely to be handy for reference. Dale's interest appears to be primarily in physical medicine and surgery, but he gives adequate and intelligent consideration to the psychiatric disorders. His discussion of Edgar Allan Poe is brief but sufficient, and Dale is of the opinion that Poe's manic-depression both preceded and underlay his alcoholism. He leaves the question of Walt Whitman's homosexuality open but discusses it adequately. There are 15 pages of references and sources for persons wishing to pursue the investigation of any individual further.



**The Birth of a Child.** Obstetric Procedures in Normal Childbirth for Those Who Attend Women in Labor. By GRANTLY DICK READ. 111 pages, 21 illustrations. Cloth. The Vanguard Press. New York. 1950. Price \$1.50.

**Introduction to Motherhood.** By GRANTLY DICK READ. 99 pages, 23 diagrams. Cloth. Harper. New York. 1950. Price \$1.75.

The author of the well-known *Childbirth Without Fear* stresses in both of these volumes the theory that the pain of childbirth is due to the factors of fear and tension. He makes definite and concrete suggestions as to how to counteract these unhealthy emotions through education for motherhood, by knowing just what is going to happen during childbirth, and, in addition to that, through training prospective mothers to have the ability to relax their bodies at will. *The Birth of a Child* contains in an appendix letters from women who describe the physical and emotional benefits they have derived from "natural childbirth." The books are simple in language and written with missionary fervor. Many a reader, lay as well as professional, critic or follower of Dr. Read's, will gather many interesting suggestions through reading these recent publications.

**Living in Balance.** By FRANK S. CAPRIO, M. D. 246 pages. Cloth. Arundel Press. Washington, D. C. 1951. Price \$3.75.

This book was apparently written for the lay reader. It is easy reading, employs non-technical terms and expresses an easy and hopeful philosophy which, to the psychotherapist, sounds a bit too easy and simple. It sets forth many bits of advice in a "1-2-3" manner; but to tell a person to stop worrying is too easy a prescription, and the patient cannot often get well on this type of medicine. Dr. Caprio's ideas are good, however, and what he really tells the reader in his book is summarized in the first paragraph, as follows: "Life is a continuous conflict and whether we remain normal or become neurotic, or even psychotic (insane), depends upon our ability to meet new situations, pleasant or unpleasant—how well we control our emotions and sublimate our unhealthy desires into good deeds, without harm to others and without detriment to that personality which is oneself."

**Many Are Called.** By EDWARD NEWHOUSE. 384 pages. Cloth. Sloane. New York. 1951. Price \$3.75.

These short stories revolve around people disgusted with, and sometimes trapped by, the pettiness and insincerity of the world around them. The author has a strong ability to provide powerful situations from the commonplace, without having recourse to the unusual in a search for material. This reviewer failed to find one story in all of the 42 that he did not enjoy, to a greater or lesser degree; a compliment he could rarely give.



**Social Psychology.** By SOLOMON E. ASCH. 646 pages. Cloth. Prentice-Hall. New York. 1952. Price \$5.50.

The purpose of this book is, as the author states, ". . . to bring some problems into sharper view, to seek theoretical and empirical clarification at some points, and where possible to sweep aside misconceptions." Thus, it has not been the author's intention to write a system of social psychology. "The time does not seem ripe for such an undertaking." Dr. Asch tells the reader to "be advised that psychology . . . does not have ready answers to our most urgent questions." He (the reader) needs to make his peace with the fact that he is approaching a pioneer field in its early stages and that the account he is invited to follow will not contain a recital of delusive achievements as much as an exploration of problems and first groping efforts at clarification.

The point of view is that of Gestalt theory and the author presents experimental findings based on his own researches. The book consists of five parts. Part I is an introductory chapter on the "Doctrines of Man." Part II consists of two chapters on "Organization in Psychological Events." Part III, entitled "Human Interaction," includes emotional interaction and a study of group interaction. Part IV deals with social needs and includes chapters on "The Ego," "Social Interest," "Rules and Values," and "The Fact of Culture and the Problem of Relativism." Part V is on "Effects of Group Conditions on Judgments and Attitudes." Here the author discusses the areas of suggestion, opinions and attitudes, sentiments and attitudes, and concludes with a discussion on propaganda.

**The Menopause.** By LENA LEVINE, M. D., and BEKA DOHERTY. 198 pages. Cloth. Random House. New York. 1952. Price \$2.50.

It would be difficult to find a better combination to write such a book than the co-authors, a woman psychiatrist and a woman journalist. One produces facts and the other gives the style. As a result, this book is especially well written and is the best one on the subject, in this reviewer's opinion, that has been written. It should be in every public library and should be found in every doctor's waiting room.

The book asks and answers five important questions: "What is the menopause? What is a woman? What really happens? What can be done? What of the future?" The authors clearly and frankly describe the physiological and psychological manifestations of the menopause and encourage the excommunication of the hopeless and fearful attitude expressed by so many women. In answering the question, "What is a woman?" the authors insist upon the emancipation of woman from her sexual taboos and obligations. ". . . The menopause is simply an event marking a change—the climax of the longest phase of a woman's life—not a tragic affliction nor a hopelessly desexing mark of age."



"What really happens?" By means of brief case records, the authors demonstrate that tradition, odd notions, hormonal deficiencies, and emotional instabilities created by temperamental and personality defects bring about severe menopausal symptoms. The authors frequently repeat that the physiological menopausal symptoms are only a small part of the total picture.

"What can be done?" The authors suggest not only a medical or physiological re-evaluation and treatment but also a re-evaluation of the woman's psychological self. They suggest, too, that there must be a re-evaluation of the family unit. "One main point to bear in mind is that all this applies to men as well as women. It is no longer possible to educate women about themselves without involving men, too, if only because men and women must live together as human beings all their lives. And particularly because men also go through a climacteric phase, preparation for them is as essential as it is for the woman. . . ."

"What of the future?" The authors express their belief that modern progressive thinking and fact-finding will alleviate many menopausal problems. "It is also important that today's young women have just about given up the age-old habit of being ashamed of themselves as women. The contemporary young woman or young girl is trained to think about herself in the most realistic fashion women have ever known. . . ."

**Alimony: The American Tragedy.** By Dr. CHARLES WILNER. 329 pages including bibliography. Cloth. Vantage Press, Inc. New York. 1952. Price \$3.50.

Dr. Wilner has crusaded against what he considers abuses in our alimony laws for nearly 30 years. The dust jacket states that he is not a misogynist: "He is happily married and the father of a grown son." But he lashes out at "our American matriarchy," refers repeatedly to the "weaker state" of women, and expresses bitterness for page after page over "feminism rampant." In another context, he notes that it is imperative that all political parties uphold "race purity." He expresses extreme opposition to intermarriage, with particular reference to Negroes. He states that he is "absolutely free from any kind of prejudice," but is "as much against race mixture as are the intelligent people of all races and climes." And he blames "feminism" for the extent of modern miscegenation.

This book covers a field full of abuses, in which a competent compilation of material should be of use to almost any social scientist. Dr. Wilner's effort at a compilation is unfortunately shrouded in Victorian sentimentality (or maybe in the Teutonic ideal of *Kirche, Küche und Kinder*), clouded by emotion, and obscured by a sweeping disregard of modern findings in social science—even those of recognized authorities whom he cites in his bibliography.



**Frontiers in Medicine.** The March of Medicine, 1950. XII and 150 pages, with Foreword by Harold Brown Keyes, M. D. (representing the Committee on Lectures to the Laity). Introduction by Iago Galdston, M. D. (as executive secretary), references and index. Cloth. Columbia University Press. New York. 1951. Price \$2.50.

"The Lectures of the New York Academy of Medicine to the Laity" are an indispensable institution of the cultural life of this country and do not require an introduction. As Dr. Galdston points out, the "consistent aim of the Academy to advance understanding in the spread of knowledge," will be furthered by these lectures. Distinguished scientists, Franz Alexander, David Seegal, Laurence H. Snyder, John H. Gibbon, Jr., Selman A. Waksman, and Thomas M. Rivers, review the progress and extension, the overlapping and restrictions of their special fields. Not only the laity will profit by studying the "frontiers in psychiatry," "the biological aspects of antibiotics" or "the concepts and methods of medical research" (to mention only three of the six lectures), the student and the physician in practice will be equally stimulated and informed about the gains and consolidated areas of medical research work.

In this place Dr. Alexander's lecture must be particularly mentioned, a lecture which he limits to the sociological implications of modern psychiatry. It is interesting to follow him through the history of human relationships with its sociologic and psychologic aspects through problems of psychologic warfare and of group dynamics to the conception of the need for a valid science of sociodynamics which in the future may contribute to "assuring a more reasonable relationship between nations."

**He Hanged Them High.** By HOMER CROY. 278 pages including index. Cloth. Duell, Sloan and Pearce. New York. 1952. Price \$4.00.

*He Hanged Them High* is a pedestrian biography of a fascinating figure, Judge Isaac C. Parker, of the United States District Court of Western Arkansas in the days of America's Wild West. His jurisdiction lasted 20 years and covered a wide, primitive and lawless territory—that is, lawless until Parker got there. Parker sentenced so many men to death that one of Croy's chapter headings reads "Judge Parker Hangs Only Five Men." Some of the most notorious figures of a vanished day appeared in Parker's court—and more in his personal story. Croy tells us that Parker was a zealot; and he seems to have been convinced indeed that he was an arm of the Lord. He sentenced with vast indignation, but there is evidence that he was not happy on the days of executions.

A study of how Parker came to be the avenger of the law and of what motivated him would be a fascinating document. Mr. Croy's report unfortunately does not provide even a skeleton upon which to drape such a tale.



**Physician to the World.** The Life of General William C. Gorgas. By JOHN M. GIBSON. IX and 315 pages including prologue, epilogue, bibliography, index and six illustrations. Cloth. Duke University Press. Durham, N. C. 1950. Price \$4.50.

The life history of Dr. William C. Gorgas, surgeon general of the United States Army during World War I, is a reflection of a cultural epoch of great significance. It is also the story of the unending idealism out of which real physicians are molded, it is the never-aging tale of the searching minds of men who remain young in their urge to know and to penetrate the secrets of nature—a book of stimulation and optimism.

That this, at the same time, represents a great era for the United States Army Medical Corps and its policy is a matter of great credit to the medical corps. Dr. Gorgas' devotion to his work, his zealous preparedness for self-sacrifice in the face of nearly unsurmountable odds, his exemplary courage, coupled with sincere modesty, rank him near the greatest of our profession.

This honest, inspiring book will be appreciated by all scientifically-minded physicians who have a flair for the cultural history of medicine. An excellent bibliography, the illustrations, and the index contribute to the book's value.

**Opportunities in Nursing.** By EDITH PATTON LEWIS, R. N. vi and 128 pages. Paper. Vocational Guidance Manuals. New York. 1952. Price \$1.00.

**Opportunities in Social Work.** By JOSEPH P. ANDERSON. vi and 112 pages. Paper. Vocational Guidance Manuals. New York. 1952. Price \$1.00.

These manuals contain a great deal of helpful information. Their coverage is not exhaustive, but they can be utilized as easily available "question answerers" by libraries, high schools, and colleges. The main fault this reviewer finds is that only too often, they sound, when discussing a career, like the local chamber of commerce drumming up business.

**Specific Dyslexia.** By BERTIL HALLGREN. 287 pages. Acta Psychiatrica et Neurologica, Supplementum 65. Ejnar Munksgaard. Copenhagen. 1950. Price not stated.

This study of "congenital word blindness" was conducted during the years 1947 to 1950 at the psychiatric clinic of Karolinska Institute in Stockholm. Two hundred and seventy-six cases were studied phenomenologically and statistically. The specialized work includes the stressing of "nervous disorders," without clarifying the unconscious tributaries.



## CONTRIBUTORS TO THIS ISSUE

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WALTER BONIME, M. D. Dr. Bonime grew up on Long Island, received his bachelor's degree from the University of Wisconsin and his medical degree from the College of Physicians and Surgeons, Columbia University, in 1938. After internship at Sinai Hospital in Baltimore he served two and one-half years at Central Islip (N Y.) State Hospital, during which time he began psychoanalytic training at the American Institute for Psychoanalysis. He entered the private practice of psychoanalysis in 1942, and in 1943 was commissioned as a passed assistant surgeon in the United States Public Health Service, in which he served for approximately three years, during most of which time he was assigned to the War Shipping Administration and was chief medical officer of the Merchant Marine Rest Center, Oyster Bay, N. Y.

Following discharge from the public health service with the rank of surgeon (major) he returned to psychoanalytic practice, and in 1947 was appointed to the faculty of the comprehensive course in psychoanalysis, post-graduate division, department of psychiatry, New York Medical College-Flower and Fifth Avenue Hospitals, and in this capacity has continued as a teaching and training psychoanalyst. He is on the staff of Flower and Fifth Avenue Hospitals, and is a member of the American Psychiatric Association and of the Society of Medical Psychoanalysts.

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BENT BORUP SVENDSEN, M. D. Dr. Svendsen is assistant physician in the department of psychiatry, Aarhus University, and the State Mental Hospital, Risskov, Denmark. A graduate in medicine of the Copenhagen University in 1946, Dr. Svendsen interned in the medical, surgical, epidemiological and neurological services in Copenhagen, in the psychiatric university departments in Copenhagen and Aarhus and in the Filadelfia Hospital for Epileptics. During 1949, he was temporary research associate in the department of medical genetics at the New York State Psychiatric Institute.

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S. MOUCHLY SMALL, M. D. Born in New York City in 1913, Dr. Small is a graduate *cum laude* of the College of the City of New York and was graduated from Cornell University Medical College with the highest standing in his class in 1937. After an internship in medicine at New York Hospital, Dr. Small became an assistant resident in psychiatry at the Institute of Human Relations (the psychiatric division of New Haven Hospital). He served later in various staff and administrative capacities at the Payne Whitney Psychiatric Clinic of the New York Hospital, the National Hospital for Speech Disorders (of which he was assistant medical



director and psychiatric consultant), and the New York Hospital Rehabilitation Clinic. He has taught at Yale, Cornell and Columbia and lectured for the Veterans Administration.

Dr. Small is at present professor and head of the department of psychiatry at the University of Buffalo, School of Medicine, and is director of psychiatry at the E. J. Meyer Memorial Hospital. He has been neuropsychiatric consultant to the surgeon general of the United States Army since 1947. Dr. Small is a member of the New York Psychoanalytic Institute and the New York Psychoanalytic Society. He is a diplomate of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association and other professional societies and has held many attending and consultative positions. He is author or co-author of numerous publications on scientific subjects including internal medicine, psychosomatics and psychoanalysis, and is author, with P. M. Lichtenstein, of the text, *Handbook of Psychiatry*, published in 1948.

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GEORGE A. SILVER, M. D. Dr. Silver, born in New Jersey in 1910, was graduated from Guilford College, Guilford, N. C., in 1934 and received his M. D. degree from the Duke University School of Medicine in 1938. After a rotating internship in Trenton, N. J., he was in private practice in New Jersey from 1939 to 1941, he served as a United States Army flight surgeon from 1941 to 1946, reaching the rank of lieutenant-colonel. After brief service with the Veterans Administration, Dr. Silver entered residence training in neuropsychiatry at Duke Hospital. He is now associate in neuropsychiatry at Duke and is engaged in research work at the State Hospital at Raleigh, N. C.

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RICHARD L. JENKINS, M. D. Dr. Jenkins is a graduate of Stanford University and of Rush Memorial College, the University of Chicago. He is chief of the research section, psychiatry and neurology division, of the Veterans Administration department of medicine and surgery, Central Office, Washington, D. C. He is the author of more than 60 scientific and professional articles.

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ELI LOCKERT BEMIS, JR. Mr. Bemis is a research analyst who prepared the basic data for the study of hospitalization, readmissions and stability of diagnoses in Veterans Administration hospitals—of which he is co-author—which appears in this issue of *THE PSYCHIATRIC QUARTERLY*. He is the author of administrative manuals for public utilities and government agencies and was on the staff of the department of medicine and surgery of the Veterans Administration at the time this study was made. He describes himself as an "occasional student of mental hygiene and public welfare."



**MAURICE LORR, Ph.D.** Dr. Lorr is a clinical psychologist on the central office staff of the Veterans Administration, division of psychiatry and neurology, at Washington, D. C. He is lecturer and research consultant for the psychology and psychiatry department of Catholic University. He received his Ph.D. from the University of Chicago in 1943 and is a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology.

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**RALPH KAHANA, M. D.** Dr. Kahana is a graduate of New York Medical College in 1946. He interned at Metropolitan Hospital, Welfare Island, New York City. Following internship, he entered the army, spending five months at Brook Army Medical Center in San Antonio, Texas, and about 18 months in the mental hygiene clinic, Fort Knox, Ky. Since 1949, he has had two years of residency training at the University of Cincinnati College of Medicine and is at present a fellow in psychiatry at Cincinnati.

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**IRVIN HYMAN WEILAND, M. D.** Dr. Weiland is a graduate of the University of Cincinnati College of Medicine in 1945. His psychiatric training was obtained at Cincinnati General Hospital and the Cincinnati Child Guidance Home. Following two years residency and two years fellowship, six months was spent as instructor in child psychiatry at the University of Cincinnati. His current appointment is instructor in child psychiatry at the University of Washington, Seattle.

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**BENSON SNYDER, M. D.** Dr. Snyder was graduated from New York University College of Medicine in 1947. After interning at Billings Hospital in Chicago, he began psychiatric training at the University of Cincinnati College of Medicine in 1949. Since January 1951, he has been with the air force, in charge of the psychiatric service at Westover Field, Mass.

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**MILTON ROSENBAUM, M. D.** Dr. Rosenbaum was graduated from the University of Cincinnati College of Medicine in 1934. He received his psychiatric and neurological training at Boston City Hospital, McLean Hospital, and Massachusetts General Hospital. He had his psychoanalytic training at the Chicago Psychoanalytic Institute. He is a member of the American Psychoanalytic Association, the American Neurological Association, and a fellow of the American Psychiatric Association. He is professor of psychiatry at the University of Cincinnati College of Medicine, associate director of the department of psychiatry at Cincinnati General Hospital and director of the department of neuropsychiatry at the Jewish Hospital, Cincinnati.



JOHN F. NEANDER, M. D. Dr. Neander received his degree of M. B. from the University of Minnesota Medical School in 1943 and his M. D. in 1944. He served in the army for two years, and served psychiatric residencies at Grasslands Hospital, Valhalla, N. Y., and at Rockland (N. Y.) State Hospital. He is now a supervising psychiatrist at Rockland, in charge of a treatment unit. Dr. Neander is a diplomate of the American Board of Psychiatry and Neurology, is a member of the American Psychiatric Association and is associate psychiatrist at the Institute for Psychotherapy, New York City.

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SAUNDERS P. ALEXANDER, M. D. Dr. Alexander attended Charles University, Prague, Czechoslovakia, and Stefan Batory University, Wilno, Poland, of which latter school he is a graduate. He is at present a senior psychiatrist at Rockland (N. Y.) State Hospital. Dr. Alexander served previously in the Polish Army Medical Corps, and, after coming to this country, served as resident psychiatrist at Rockland, consultant in endocrinology at Rockland, and attending psychiatrist at the Rockland outpatient clinic. He is a member of the American Psychiatric Association.

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DONALD L. GERARD, M. D. Dr. Gerard is a graduate of the Long Island College of Medicine, in 1947. He interned at the New York Polyclinic Medical School and Hospital, and obtained psychiatric training at Brooklyn (N. Y.) State Hospital and at Worcester (Mass.) State Hospital. In January 1951, he entered the United States Public Health Service and was assigned from the National Institute of Mental Health to its collaborative research project with the Worcester Foundation for Experimental Biology. There he participated in a multi-disciplined research program investigating adrenal cortical function and the differential reactions to experimental stresses of normal and psychotic men.

In September 1951, he was assigned to the Addiction Research Center of the United States Public Health Service Hospital in Lexington, Ky., to study adolescent opiate addiction. Since July 1952, he has been in New York City continuing this research. In addition to clinical work, Dr. Gerard is especially interested in research dealing with the area where the social sciences and psychiatry overlap. Previous publications by him have appeared in this and other journals.

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LESTER G. HOUSTON, M. S. Mr. Houston is consultant on community mental health programs for the Massachusetts Association for Mental Health. Born in Newton, Mass., in 1921, he is a graduate of Howard University, Washington, D. C. He received his graduate degree (M. S. in S. S.) from the Boston University School of Social Work in 1947. For four



years he served the Massachusetts Department of Mental Health as psychiatric social worker; first in the Lowell Child Guidance Clinic, then at the Worcester Psychosomatic Clinic and in the research service of Worcester State Hospital. Mr. Houston was also engaged for a year as community relations secretary of the Boston Urban League. He is a member of the American Association of Psychiatric Social Workers.

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**STELLA CHESS, M. D.** Dr. Chess has been with the Northside Center for Child Development in New York City since 1946, and is now co-ordinating psychiatrist there. A graduate of Smith College, she received her medical degree from New York University in 1939. She served an internship at Montefiore Hospital, served in the psychiatric division of Bellevue Hospital Children's Ward, and served a residency in the psychiatric department at Grasslands Hospital, Valhalla, N. Y. She has completed a course of psychoanalytic training at New York Medical College, as well as a personal analysis, and is now a member of the post-graduate psychoanalytic faculty of New York Medical College.

Formerly resident psychiatrist at Pleasantville Jewish Child Care, she has been in psychiatric work with children since 1941; she has been consulting psychiatrist for the Riverdale Children's Association since 1942. She is an associate in psychiatry and assistant psychiatrist at Flower-Fifth Avenue Hospitals. Dr. Chess is author or co-author of a number of scientific articles dealing with psychiatric and behavior problems in children. She is a member of the American Psychiatric Association, the American Orthopsychiatric Association, the Society of Medical Psychoanalysts and other professional organizations.

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**KENNETH B. CLARK, Ph.D.** Dr. Clark received his bachelor's and master's degree from Howard University, and his Ph.D. from Columbia in 1940. He is associate director and co-ordinator of the psychology department of the Northside Center for Child Development, New York City, a position he has held since 1946; and he is assistant professor of psychology at the College of the City of New York, where he has been on the faculty since 1942. Dr. Clark has taught psychology at Howard University and at Hampton Institute, and has been research psychologist for a number of scientific studies, including service with the O. W. I. on a study of morale in minority groups. He was research psychologist for the American Jewish Congress for two years before assuming his present position at the Northside Center. Dr. Clark is visiting professor on the subject of changing social attitudes at the New School for Social Research, and on the subject of social psychology at the William Alanson White Institute of Psychiatry. In 1950, he served on the fact-finding committee for the Midcentury White House Conference on Children.



He is the author of more than 20 scientific articles, mostly dealing with race and color problems, a number of them particularly concerned with children. Dr. Clark is a member of the American Psychological Association and other professional bodies.

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ALEXANDER THOMAS, M. D. Dr. Thomas is a graduate of the College of the City of New York; he received his medical degree from New York University College of Medicine in 1936. He is now a clinical instructor in psychiatry at that institution and is an assistant visiting psychiatrist at Bellevue Hospital. He is a diplomate of the American Board of Psychiatry and Neurology.

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EDWARD L. MARGETTS, M. D. Dr. Margetts was graduated from the University of British Columbia in 1941 and received his M. D., C. M., from McGill University in 1944. He is certified in psychiatry by the Royal College of Physicians and Surgeons of Canada, and holds a diploma in psychiatry from McGill. He is in private practice in Montreal, is a lecturer in psychiatry and in the history of medicine at McGill, is honorary librarian of the Allan Memorial Institute of Psychiatry and is assistant psychiatrist at the Royal Victoria Hospital, Montreal. He lists his principal interests as trying to find enough time off from his practice for research in the history of psychiatry, and as promoting interest in the history of psychiatry.



## NEWS AND COMMENT

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### KAREN HORNEY, M. D., PSYCHOANALYST, DIES AT 67

Karen Horney, M. D., psychoanalyst, author and educator, died in New York City on December 4, 1952, after an illness of two and one-half weeks. She was 67 years old.

Born Karen Danielson, in Germany of a Norwegian father and a German mother, Dr. Horney studied at the Universities of Freiburg and Göttingen and was a graduate in medicine of the University of Berlin in 1913; she became a practising psychoanalyst in 1918 and taught at the Institute of Psychoanalysis in Berlin from 1920 until 1932 when she came to this country to become associate director of the Institute for Psychoanalysis in Chicago at the invitation of Dr. Franz Alexander. She remained in the United States and became an American citizen in 1938.

From 1934 until 1941, when she became dean and trustee of the American Institute for Psychoanalysis, a school based on her teachings, she taught at the New York Psychoanalytic Institute. She had practised in New York City since 1934. Dr. Horney developed her own analytic theories and became the founder and leader of an important psychoanalytic group. Her book, *New Ways in Psychoanalysis*, presented some of her theories and techniques. Her other works included *The Neurotic Personality of Our Time*, *Self-Analysis*, *Our Inner Conflicts*, and *Neurosis and Human Growth*.

Dr. Horney had planned a medical career from childhood, when she was impressed by a man she later described as a "nice country doctor." During her career in Berlin, she became widely known internationally and was a participant in the discussion on lay analysis conducted by Freud. She had an early background of travel, having taken voyages with her sea captain father when she was a child. She was devoted to painting as a hobby, and the walls of her apartment were decorated with her own landscapes. Dr. Horney was married to Oscar Horney of Berlin while she was still a medical student. She leaves three daughters, one in New York, one in Washington, and one in Mexico City.

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### PSYCHOSOMATIC SOCIETY FORUM DATES ANNOUNCED

The American Psychosomatic Society has announced the holding of two New York City psychosomatic forums on February 3 and March 11, 1953. Attendance is open to all interested persons. Paul H. Hoch, M. D., of the New York State Psychiatric Institute will be chairman for the February 3 forum, which will be conducted at 8:30 p. m. in the Blumenthal Auditorium of Mt. Sinai Hospital.



## NEW YORK REPORTS 27 NEW MENTAL HEALTH FACILITIES

Establishment in the last three years of 27 new local mental health facilities in New York State has been announced in a progress report to the governor and legislature by the New York State Mental Health Commission. In addition to the setting up of these facilities with state financial aid and advisory service, the commission reports educational activities including the providing of tuition for 247 staff members of the New York State Department of Mental Hygiene who have taken professional training courses on their own time, and the granting of 150 scholarships for persons in the disciplines allied to medicine.

Six research projects are reported, many of them dealing with the mental health problems of an increasingly older population; and during the present year, 29 social agencies are receiving a total of \$220,000 in funds through the commission. A current special project deals with the problem of alcoholism, with the co-operation of the New York State Department of Health as well as the Department of Mental Hygiene. State grants to two community clinics for chronic alcoholics have been announced. The mental health commission is comprised of the heads of five state departments, with Commissioner Newton Bigelow, M. D., of the Department of Mental Hygiene as chairman.

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## FORM FOR OUT-PATIENT CLINIC REPORTS DRAFTED

The National Institute of Mental Health, in consultation with interested organizations, announces the development of a preliminary report form for collection of nation-wide statistical data in the field of out-patient psychiatric clinics where such figures are not now available. Plans call for the distribution of forms and instructions early this year, with the first nation-wide report to be compiled in 1954. Preliminary drafts of the proposed form have already been distributed to state authorities and national organizations concerned; and the institute is awaiting comments and suggestions before making the final draft. Interested groups who have not received copies of the preliminary form may obtain them on request from the institute.

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## DR. GREGORY RETIRES; DR. RODGERS NEW DIRECTOR

Dr. Hugh S. Gregory, director of Binghamton (N. Y.) State Hospital since 1942, retired on January 1, 1953 after 40 years in the state service. Dr. Arthur C. Rodgers, assistant director of Creedmoor State Hospital, was named director of Binghamton to succeed him. Biographical notes on Dr. Gregory and Dr. Rodgers will appear, as is customary, in THE PSYCHIATRIC QUARTERLY SUPPLEMENT (Part 1, 1953).



**DR. MARCUS A. CURRY, FORMER GREYSTONE PARK HEAD, DIES**

Dr. Marcus A. Curry, former medical superintendent of New Jersey State Hospital at Greystone Park, died at that hospital on November 11 after a brief illness. He was 74 years old. Dr. Curry, a graduate of Albany Medical College in 1904, engaged in private institutional work following his internship before joining the staff of Central Islip (N. Y.) State Hospital. He left Central Islip in 1909 for Greystone. He had been in the New Jersey state hospital service for 41 years when he retired in 1950.

Dr. Curry was a life member of the American Psychiatric Association and was active in both professional and other organizations. As head of Greystone Park, he was one of the principal participants in the widely-known Columbia University-Greystone Park research project in topectomy, in which professional staff members of the New York State Department of Mental Hygiene also participated. Dr. Curry was credited with many advances in New Jersey institutional practice, including the provision of greater freedom for mental patients, the encouragement of recreational and occupational therapy and the establishment at Greystone Park of a pioneer school of nursing.

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**JOSEPH H. GLOBUS, M. D., DIES AT 66**

Dr. Joseph H. Globus, internationally known for his work in neuropathology, neuroanatomy and neurology, died of a coronary thrombosis at his home in New York City on November 20, 1952. A co-worker with Harvey Cushing, Bernard Sachs and others, he was regarded as one of the founders of the modern American school of neuropathology. Born in Russia, he came to this country as a boy, was graduated from Columbia University, and received his medical degree from Cornell in 1917. He interned at Montefiore Hospital, New York City, and at Manhattan (N. Y.) State Hospital, and did post-graduate work in Germany.

Dr. Globus taught at Columbia, Cornell and New York University, and was author of the text, *Practical Neuroanatomy*, and many scientific articles. He was editor of *The Journal of Neuropathology* and *Experimental Neurology* and of *The Journal of the Mount Sinai Hospital*. He was a former president of the American Neuropathological Society and was an active member of other professional organizations. He is survived by his widow, two sons and a daughter.

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**DR. BABCOCK NAMED HEAD OF BUTLER HOSPITAL**

Henry H. Babcock, M. D., acting superintendent and physician-in-chief since May 1951 of Butler Hospital, Providence, R. I., has been named permanently to that post by the board of trustees of the institution.



## CHILD GUIDANCE PSYCHIATRY FELLOWSHIPS ANNOUNCED

Availability of a number of fellowships offering specialized training in child psychiatry is announced by the American Association of Psychiatric Clinics for Children. The training is in specialization for child psychiatry, particularly for work in community clinics for out-patient treatment. It begins at third-year post-graduate level; and minimum prerequisites include graduation from an approved medical school, approved internship and a two-year residency in psychiatry. The majority of the stipends are provided by the United States Public Health Service and are about \$3,600 annually, although stipends may be paid from other sources or supplemented by work in addition to the training program.

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## HARRIET BABCOCK, Ph.D., PSYCHOLOGIST, DIES AT 75

Harriet Babcock, Ph.D., clinical and research psychologist and author of a number of widely-known books on her specialty, died in New York Hospital on December 17, 1952 after a long illness. She was 75 years old. Dr. Babcock was the widow of H. Hobart Babcock. She taught in the Rhode Island schools for some years before going to Columbia where she received her B. S. in psychology in 1922, her M. A. in 1923, and her Ph.D. in 1930.

In psychological research, Dr. Babcock specialized in clinical work in the efficiency phase of mental functioning, a phase to which she had devoted her efforts since 1931. Earlier Dr. Babcock had served as psychologist for Manhattan (N. Y.) State Hospital and chief psychologist for Bellevue. She was the author of *Time and the Mind* and other psychological books and scientific articles.

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## L. S. U. ANNOUNCES PSYCHOLOGIST-TRAINING PROGRAM

Louisiana State University has announced a four-year training program for clinical psychologists, leading to a Ph.D. degree, in an educational effort described as unique in the south. The program, carried out by co-operation of the College of Arts and Sciences and the School of Medicine, is designed to train clinical psychologists for Louisiana state institutions and other institutions in the south.

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## UNIVERSITY HONORS NIEDERLAND

William D. Niederland, M. D., of New York City has received the 1952 annual achievement medal of the University of Tampa "in recognition of achievements in intercultural education, intergroup-understanding and mental health." Dr. Niederland was professor of psychology at Tampa in 1946-1947.



**GROUP DEVELOPMENT SESSIONS SET FOR JUNE AND JULY**

The National Training Laboratory in Group Development will conduct its annual three-week session from June 21 through July 11, 1953 at Gould Academy, Bethel, Me. About 110 applicants will be accepted for the session, and persons involved in problems of working with groups in training, consultant and leadership capacity in any field may apply. The annual laboratory sessions are sponsored by the division of adult education service of the National Education Association and by the University of Michigan. Group skills of analysis and leadership are practised in role-playing and observer techniques. Application of the laboratory work to jobs at home is discussed during the last week of the session.



## CONCERNING THE NATURE OF COMMUNICATION\*

BY ERIC BERNE, M. D.

### I. CYBERNETICS AND PSYCHIATRY

The physical and engineering aspects of control devices, calculators and communication systems<sup>1</sup> are now related to a body of precise theory.<sup>2</sup> This science, which has been called cybernetics<sup>3</sup> is gradually expanding into territory which is familiar from another point of view to psychologists, psychiatrists, and psychoanalysts. Cybernetics leads from consideration of physical devices like telegraph cables to attempts at precise mathematical analysis of such formulations as for example, the following: "numerous observations—comparison—thinking—scientific laws—practical application of these laws—new apparatus or machines built."<sup>4</sup>

The inspection of such a sequence makes it clear that students of mental science have a pertinent interest in these developments. Communication theory has a great deal to say about the mechanics of certain operations at which living organisms are peculiarly adept, especially in connection with the ability to respond selectively to signals received.<sup>5, 6</sup> Cybernetics has hitherto received relatively little attention in the psychiatric literature, although a good deal of discussion by clinicians is mentioned or found in sources not ordinarily consulted by clinicians.<sup>3a, 7</sup> Some physiologists have actually constructed cybernetic mechanisms as representatives of brain function.<sup>8, 9, 10</sup> Shannon<sup>5</sup> proposes a chess-playing machine. Meanwhile, the psychological aspects of communication have aroused considerable interest.<sup>11\*\*</sup> But the number of fortunate people who have had both intensive training in the theory and practice of communication engineering and extensive experience in dynamic psychotherapy appears to be stringently limited. The specialist in either field hesitates to venture as a layman into the other because of the pitfalls which tempt the uninitiated in such complex matters. Nevertheless it seems worth while to run some risks for the sake of scientific empiricism.

\*Modified from a paper read at the Psychology Seminar of the Langley Porter Clinic, San Francisco, March 1950.

\*\*Dr. W. R. Ashby of Gloucester, England, conducted the meeting on cybernetics at the International Congress of Psychiatry in Paris in 1950. At this meeting, which was attended by a group with quite heterogeneous viewpoints, little inclination was shown to discuss the subject from the psychological point of view.



Some "cyberneticists" mention or even emphasize the analogies between their machines and the brain, or even the mind: "The realization that the brain and the computing machine have much in common may suggest new and valid approaches to psychopathology, and even to psychiatrics."<sup>3b</sup> Others stress the essential differences: "Active thinking has been done by the designers of the machine and is done by the staff of scientists using the machine. Creative thinking is not to be found in the machinery itself."<sup>4</sup>

Cyberneticists, coming in one direction from theoretical physics and practical experience with communication systems and calculating machines, are able to state: "The information carried by a precise message in the absence of a noise is infinite. In the presence of a noise, however, this amount of information is finite, and it approaches 0 [zero] very rapidly as the noise increases in intensity."<sup>3c</sup> "No communication mechanism, whether electrical or not, can call on the future to influence the past, and any contrivance which requires that, at some stage, we should controvert this rule, is simply unconstructible . . . once a message has been formed, a subsequent operation on it may deprive it of some of its information, but can never augment it."<sup>12</sup>

What has the psychotherapist, coming in the other direction from his clinical work, to say about these statements? He can make certain comments and discuss them on the basis of his own experience: First, that the notion of "a precise message" or "a message which has been formed" is psychologically inconceivable in interpersonal communication. Second, that in contrast to mathematical "information," the amount of psychological information increases rather than decreases with increasingly intense (intrinsic) "noise." Third, that human beings, in their interpersonal communications, do seem to call successfully on the future to influence the past.

The mathematician is able to discuss "noise" and "information" from a formal, syntactic point of view in terms of entropy,<sup>2, 3, 4</sup> relating them as quantities to formulations of the second law of thermodynamics. The psychologist regards noise and information semeiotically from the pragmatic aspect. According to the common notion, as expressed in dictionaries, *noise* means "a disturbing or discordant sound." It is an emotional word. To say, "I hear a noise!" still means to most people, "I am disturbed." To say, "I have information!" means, "I know something." The common no-



tion of noise usually connotes "what I don't want to hear," and of information "what I do want to hear." The mathematician, in speaking, for example, of "combating noise" and "undesirable uncertainty," seems to accept these axiological connotations,<sup>2a</sup> which the psychiatrist expresses as the anxiety aroused by noise and the feeling of security which comes from knowing something, respectively.

Since the psychiatrist is generally not equipped to deal rigorously with the mathematical concepts of "noise" and "information," it is fortunate that the mathematician sometimes indicates, implicitly and explicitly, that his discussions of these two quantities are influenced by the concepts of "desirability" and "intention." This provides a common area where the two disciplines overlap in their study of communication. If the psychiatrist defines information from the communicant's point of view as what he advertently desires and intends to communicate, and noise as what he inadvertently communicates without desiring or intending, an interesting situation arises. If we term the communicant for the moment a "machine," this may be stated as follows: Noise is the only factor which communicates operationally anything about the variable state of the machine itself. Information can communicate nothing about this except as a proposition whose verification depends upon scanning the noise. A machine which worked without noise would communicate nothing about the variations in its own state. When a message is desired about those variations, it must be derived from noise.

In interpersonal communication, such a message may be desired by the receiver. From the receiver's point of view, information can be defined as what he advertently desires and intends to receive, and noise as what he inadvertently receives without desiring or intending to receive. The reception of noise by the receiver interferes with his reception of information so that his reception is equivocal. If the receiver (in interpersonal communication) is interested in an apparently precise, formed message which the communicant desires and intends to transmit, then their definitions of noise and information coincide. But if the receiver is interested in the state of the communicant, then what is noise to the communicant becomes information to the receiver, and what is information to the communicant becomes noise to the receiver, since it interferes with his clear reception of the message he desires to receive.



so that his reception is equivocal. Thus in the psychological situation, what is information at one moment can become noise at the next moment, and vice versa, by a mere change of attitude on the part of the receiver. Furthermore, since the receiver can re-evaluate what has already happened, what was noise in the past can become information in the future, and vice versa. The situation is somewhat analogous in the case of machines, insofar as they are objects of human observation. Although these statements are based on a shift in defining "noise" and "information" from the syntactic to the pragmatic point of view, they nevertheless present aspects to be considered in any mathematical theory of communication which takes psychological factors into account.

This position can be generalized psychologically in the following proposition: In the case of any machine which is a "black box" (the communicant), the amount of information which can be derived concerning the state of the machine itself is a direct function of the (intrinsic) noise. If the machine functions perfectly, this type of information is limited to the information that it is functioning perfectly. Specifically, a theoretically perfect diplomat reveals nothing of his inner life. The only information he communicates about himself to others is that he has perfect manners. On the other hand, the ambivalence of an ardent lover or a deadly enemy is communicated only by the noise, if any, which contaminates the precisely formed message he intends to convey. It might be possible to increase the area of mutual understanding between cybernetics and psychology by analyzing this proposition in terms of entropy in such a fashion as to make the analysis psychologically cogent. P. W. Bridgman<sup>13</sup> pointed out the difficulty in dealing in terms of entropy with any system containing living organisms. This difficulty may arise *a fortiori* in the case of psychological systems; nevertheless, some psychologists have been sufficiently intrigued by the possibility to write about it.<sup>14</sup>

It might appear that the problem is no more complex than dealing by communication theory with a talking movie of a person who is not acting, so that, for example, the sound track and the pictures may be regarded as noise and information respectively, or vice versa. But it is not that simple. In interpersonal communication, the message is not manifest immediately to the receiver any more than it is to the communicant; and both parties may be exerting strenuous efforts to confuse noise with information, and vice



versa. Common clinical examples of these deceptive maneuvers are as follows: 1. "I'm talking a lot, therefore I'm telling you a lot." 2. "My slip of the tongue was accidental, therefore you must not judge me by it." 3. "He says he loves me, therefore he does." 4. "She forgot my birthday because she is absent-minded." Whether it is possible to relate these complications to matters which the mathematician is already capable of dealing with, such as memory and coding, remains to be seen.

## II. THE LATENT COMMUNICATION

The position taken here that is to be justified heuristically in regard to interpersonal communication, especially in the clinical situation, is as follows: That the notion of "a precise message" is psychologically inconceivable; that the amount of potential psychological information increases rather than decreases with increasingly intense (intrinsic) noise; that the future can be successfully called upon to influence the past.

The crux of the matter from the psychological viewpoint is the differentiation between "manifest communications" and "latent communications." To illustrate this, it is convenient to consider first a communication which is indirect in time, place, and person, such as a message from antiquity.

An interesting and cogent example is the Rhind Papyrus.<sup>15</sup> Thirty-six hundred years ago, an Egyptian scribe named Ahmose was attempting to communicate to some countrymen a clever method of dealing with problems in arithmetic. Reading the English translation today, one cannot help being interested in the manifest communication, which describes a fascinating but highly inefficient method of solving such problems. This method is what Ahmose desired and intended to communicate. But to the modern reader, even more interesting is what he did not advertently intend to communicate, the communication latent in his papyrus, which concerns, among other things, a certain amount of carelessness, a lack of intellectual integrity, a preponderant interest in food and how to preserve it from the ravages of mice, and an undemocratic attitude.

A prehistoric kitchen-midden is an even more striking example of a latent communication, since it was not intended as a communication at all and yet communicates a great deal to future generations, e. g., dates.<sup>16</sup>



With this preparation, one can approach the more subtle situation met with in the direct, *vis-à-vis* communications of clinical practice. At a certain stage of his treatment, a patient bought a recording machine. He would dictate his dreams during the night and proudly bring the machine to the psychiatrist's office in the morning and run them off. This was intended to demonstrate his efficiency and co-operation, but instead showed his fear of interpersonal relationships and his hostility to the psychiatrist. He filled the machine with manifest communications which were of far less importance at the time than the latent communication signified by his purchase of the machine for this sole purpose. Furthermore, his eulogies of the machine inadvertently revealed far more about himself than they did about the recorder.

From the consideration of examples such as these, it becomes evident that the value of a communication (to the receiver) cannot be set by the communicant, but only by the receiver. No matter how anxious the communicant is to form a precise message, his communication cannot be limited to what he intends. Furthermore, the unintended communications, which from his point of view are "noise," are of more psychological value than the intended ones. But this depends on what the receiver regards as information; the patient's wife, for example, was unable at the time to see any significance in his purchase of the machine. During her own subsequent treatment, however, it happened that a great many of her husband's actions which she had previously ignored now became very informative, so that what had previously seemed like a lot of noise was transformed into information, particularly when she took the timing and the status of the communicant into account. Similarly in the case of the papyrus, the precise message which Ahmose intended is not so precise after all, and the less precise it is, the more we learn about Ahmose and his people, mainly because our distance in time from their culture enables us to be more objective. The random, disarranged, and once noisome kitchen-midden also becomes very informative after the lapse of many centuries.

In the case of interpersonal relationships, in general, intended, precise, formal, rational, verbal communications are of less value than inadvertent, ambiguous, informal, nonrational, nonverbal communications; for in such cases the receiver is not interested in the information the communicant intends but in the psychological



reality behind it.\* "Arithmetical problems about granaries can be solved," means at the most superficial psychological level: "I am interested in granaries"; and "I am co-operative" means "*I feel I should tell you at this time that I am co-operative.*"

These observations make certain defining statements possible from the psychological point of view. Any emission of energy which affects an organism may be called a communication, providing it is understood by the receiver. For example, Mario Pei refers to "the broader definition of language" as "any transfer of meaning."<sup>18b</sup> Whatever can be understood is a *communication*. Whatever cannot be understood is not a communication. Only a person who understands the actions of bees can receive communications from them.<sup>21</sup> An image on a television screen is a communication to the public; "snow" on the screen is a communication only insofar as the receiving organism understands how television works.

A communication is *understood* when it changes the distribution of psychic cathexes in the receiving organism. Any change in the psychic cathexes in an organism, such as that brought about by a communication, changes its potentialities for action. Cathexis refers to the charge of "psychic energy" on a psychic image, and the investment of such an image with feeling and significance. Not everything which changes cathectic distribution and, hence, poten-

\*These are principles well known explicitly or implicitly to all psychiatrists and psychologists, and for that matter to all physicians. The probability of their validity is increased by the fact that students of other disciplines, viewing other aspects, come to similar conclusions. Among linguists, for example, E. H. Sturtevant (Ref. 17) takes an almost cynical position: "All real intentions and emotions got themselves expressed involuntarily, and as yet nothing but intention and emotion had called for expression. So voluntary communication can scarcely have been called upon except to deceive; language must have been invented for the purpose of lying." Concerning the specificity of nonverbal communications, another linguist, Mario Pei (Ref. 18), says: "It is further estimated that some seven hundred thousand distinct elementary gestures can be produced by facial expressions, postures, movements of the arms, wrists, fingers, etc., and their combinations." Seven hundred thousand is more than the number of words in the English language, including a few hundred thousand archaic and technical terms (Ref. 18a).

Still, as to the relative values of verbal and nonverbal communications, there are contrasting viewpoints. Darwin (Ref. 19) says: "The movements of expression . . . serve as the first means of communication. . . . They reveal the thoughts and intentions of others more truly than do words, which may be falsified." Freud (Ref. 20) remarks on the other hand: "Speech owes its importance to its aptitude for mutual understanding in the herd, and upon it the identification of the individuals with one another largely rests."



tialities for action, is a communication: Metabolic changes, fantasies, and dreams may do the same thing. The *value* of a communication is the extent to which it changes quantitatively the cathectic distributions in the communicant and the receiver and, hence, their potentialities for action. The value is the quantitative aspect of the quality of being understood, and changes on a time scale. It is principally discussed here from the receiver's viewpoint. *Interpersonal* communication generally refers here to *vis-à-vis* communication which influences the development of the relationship between the autonomous portions of the personalities concerned. *Intend* (in this discussion of the latent communication) is used with its common dictionary implication of conscious design, determination, and direction.

### III. CLINICAL APPLICATIONS

In the case of machines, there are at least two kinds of messages received: One is the message which is put into the machine as information; another is the message which the machine sends about its own state as noise. Similarly, there are two kinds of communications between people: One refers to the manifest topic of communication, the other to the state of the communicant. The latter, as psychiatrists know, is generally latent, for if a man is asked: "How are you?" he reveals the true state of affairs, not by the manifest content of his reply, but by his manner, his choice of words, and a multitude of other clues. It has been traditionally agreed for at least five thousand years that in the development of interpersonal relationships, the state of a communicant (with regard to *Maat*, or righteousness, for example) is more important than what he or she is saying. In the present terminology, the latent communication is generally of more value in this regard than the manifest communication. Its superior value is well known to the layman who remarks: "It's not what she says, it's the way she says it!"

There must be some way for the receiver to understand the latent communication. With a certain part of his ego, the communicant tries "to form a precise message." But what comes out is a configuration to which many functions make their contributions and through which they potentially reveal themselves. The receiver understands as much of this as he is ready to, but it seems always more than the communicant advertently intended. Just as the



communicant communicates, so the receiver perceives through a configuration of many functions. What is important is that he understands more than he is aware of, just as the communicant reveals more than he is aware of. What he understands but is not aware of is his "latent response" to the communication. He may or may not eventually become fully aware of all that he understands, but his psychic cathexes are redistributed and his potentialities for action changed much more than he is aware of at a given moment. The following case demonstrates the nature of the latent response and that it is on the basis of the latent response that the receiver relies on the future to rearrange the past into new components of noise and information. It also shows how in the mind, information does not "exist"; it "becomes."

A man who was courting a widow tried to curry her favor by lavishing attention on her children and her dog. He frequently stated with apparent sincerity, "I love children and dogs." The widow's manifest response was to think, speak, and act with conscious intent as though she accepted his manifest communication at face value. But along with the latter she received an impression which was not yet a manifest response. She noticed that his voice had a peculiar tone when he made this declaration. This tone was "noise" in many senses of the word. It was not intended, it communicated no information about his love (at the time), it was a vibration of the "machine" which made his words less clear, and it was disturbing. On one occasion, she observed him (without his knowledge) snarling at a child, and on another occasion kicking a dog. On each of these occasions an interesting event took place: A lot of "noises," of whose value and import the widow was not previously aware and which she had never intended to notice, were suddenly integrated so that her attention was adverted to them and they became informative: "He was lying *all along* when he said he loved children and dogs." The wooer's manifest communication had carried with it some latent communications. These activated in the widow a fund of inadvertent latent responses which led to her feeling of uneasiness. When his insincerity became manifest, her stored-up latent responses became manifest to her. While they were still latent, however, they were understood in the sense that they changed her potentialities for action so that, without precisely knowing why or consciously planning to, she maintained a certain reserve and spied upon him a little.



This example attempts to demonstrate why certain responses are called "latent" and why such latent influences are called "responses." The distinction between latent responses and latent content must now be discussed. A young scientist was greatly interested in the very subject discussed here: the relationship between cybernetics and psychology. He maintained that his ideas on the subject were objective, and on the surface they appeared so, but it soon became evident that he had a response of which he was not aware, to the problem. He became very defensive when the inclusion in his discussion of a certain quotation was questioned, a remark of O'Brien's in Orwell's *1984*: "Do you suppose our mathematicians are unequal to that?" It soon appeared that the literature he had read on communication theory had made him uneasy, so that quite unconsciously he had developed a hostile attitude, for he feared that further progress in the subject would reduce the esthetic values in human society. His latent response to the manifest and latent communications of the mathematicians was highly charged with resentment toward them. But the latent content of his hostility referred to something far in the past: his fear that his very conscientious ("mathematical") father would deprive him of the pleasure of having romantic ("esthetic") fantasies about his mother. He had a latent response (which became manifest in analysis) about the mathematicians, based on latent content about himself.

A woman reported: "I dreamed about a kitten." Both her latent communication, and the latent response in the analyst's mind were, as they both discovered later, something about a miscarriage, although at the time they talked about cats. The latent content in her mind, which determined her latent communication, was about herself, and the analyst's latent response was also about her and not about himself. In general, latent content refers to the latent perception of what concerns the individual's own psychology; latent response refers to the latent perception through communication of someone else's psychology, or, more broadly, to the latent perception through communication of something about external reality. Doubtful cases are taken care of in a formal way by defining communication as an understood emission of energy which affects the organism. The psychiatrist's latent response in clinical communication is usually a response to: the patient's latent response to a previous communication, plus the patient's latent con-



tent. For example: "This patient doesn't know that he is angry at what I said, which reminds him of earlier experiences; is that why I'm being unusually careful of what I say? And conversely for the patient sometimes, *mutatis mutandis*. For example: "The doctor doesn't know that he is responding to my provocation because of his earlier experiences; is that what I have to settle with him?"\*

The concept of the latent response may now be recognized as having some familiar connotations. In clinical practice it refers to the latent communication of the subconscious reactions of the patient to his situation and to the subconscious perception of these reactions by the analyst, ideally without any interference from his own anxieties. In other words, it applies in this situation mainly to the perception of the transference reactions with a minimum of interference from counter-transference or anxiety, excluding what the analyst is able to verbalize to himself immediately. The peculiar skill of the analyst in this respect is to be able to detect more than is ordinarily detected of the latent communication. This skill comes through training in detecting his own latent responses and in purifying them by segregating the latent thoughts caused by counter-transference and anxiety. This is not meant to imply that there is necessarily a one-to-one relationship between a manifest communication and a manifest response, or between a latent communication and a latent response, although there is an empirical relationship.

Another familiar aspect of the latent response is its relationship to the unconscious or preconscious perceptive ego, that is, to intuition. In other words, the latent response to a communication is the intuitive knowledge of the receiver. Intuition may be described as follows:<sup>23</sup> It is one part of a series of processes (a segment of an epistemological spectrum) which work above and below the

\*The latent response may be represented by, but is not identical with, a preconscious stream of associations in the mind of the receiver. This stream of thoughts can sometimes be detected by introspection while listening. It may be more or less influenced by the latent content which the communication activates in the receiver and is usually a compromise formation of the two influences: the latent response and the latent content which the manifest and latent communications activate. Patients often seem to respond to this stream of associations, when it occurs, rather than to the manifest communications of the analyst. T. Reik, (Ref. 22a) offers some good examples of this preconscious phenomenon. He also describes excellently some latent responses, though not by that name (Ref. 22b). All this is difficult to state more simply because of the multiplicity of vectors.



level of consciousness in an apparently integrated fashion, with shifting emphasis according to special conditions. Intuition is knowledge based on experience and acquired through sensory contact with the subject by means of pre-verbal unconscious or pre-conscious functions, so that the intuiter at first cannot formulate to himself or others exactly how he came to his conclusions. This means that the individual can know something without knowing how he knows it. He may not even know what it is that he knows, but behaves or reacts in a specific way as if his actions or reactions were based on some special knowledge.\* In fact, he may not even know that he knows something, yet behaves as if he did.<sup>26</sup>

The receiver may not be aware that anything has been communicated besides the manifest content; or, if he is, he may not know how the latent communication is conveyed. Nevertheless, the distribution of his psychic cathexes is changed so that he behaves or reacts as if he had some additional understanding.

It is interesting to note that, in general, women seem to be more aware of, and to place more value consciously on the latent communication than men. For example, they are more apt to be aware of being influenced to a greater degree by a man's mood, zeal, or tone of voice than by what he says. Many men prefer to think that they are primarily influenced by the manifest communication.

#### SUMMARY

Psychological aspects of the mathematical concepts of "noise" and "information" are discussed. Although these concepts are now mathematically related to the second law of thermodynamics, their evaluation still involves psychological problems. The most important point in this respect is that it is "noise" and not "information" which signals the state of the machine itself. This introduces an apparent paradox in the study of communication when "noise" and "information" are defined from a psychological point of view.

An attempt is made to justify heuristically some important differences in communication theory between the mathematical (syntactic) and the psychological (pragmatic) points of view. The

\*This is reminiscent of Schilder's statement regarding dogs: "It is also true that the sound which for the dog has become a promise that feeding will occur is no longer like any other sound. It has gone through many more constructive processes. For the dog the sound has the import of feeding." (Ref. 24.) Schilder epitomizes the situation when he speaks of the prior wordless state that every thought goes through before it is formulated. (Ref. 25.)



psychologist differs from the mathematician in considering: (1) that the notion of "a precise message" is psychologically inconceivable; (2) that the amount of potential psychological information increases rather than decreases with increasingly intense (intrinsic) noise; (3) that the future can be successfully called upon to influence the past.

In interpersonal communications, "noise" is of more value than "information," since in such cases it is of more value to the communicants to know about each other's states than to give "information" to each other. "Noise" carries latent communications from the communicant. Manifest and latent communications arouse latent responses in the receiver which are important to both parties and are of special interest to psychiatrists.

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# A THREE-YEAR FOLLOW-UP STUDY OF NONCONVULSIVE HISTAMINE BIOCHEMOTHERAPY, ELECTRIC CONVULSIVE POST- HISTAMINE THERAPY, AND ELECTRIC CONVULSIVE THERAPY CONTROLS

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In a series of previous communications, the following aspects of the role of histamine in psychiatry have received extensive discussion:

1. The possibility of histamine liberation in tissues by the passage of an electric current of the intensity used in electric convulsive therapy (ECT).<sup>1</sup>

2. The possibility of histamine being a naturally occurring body hormone, having broad physiologic significance. It has been implicated negatively in the hypochlorhydria of psychosis<sup>2</sup> and positively in the stimulation of gastric hydrochloric acid secretion following electric convulsive therapy<sup>3</sup> and also perhaps during insulin therapy of psychotics.<sup>4</sup>

3. The use of histamine as an effective biochemotherapeutic agent in psychosis,<sup>5-10</sup> and the additional beneficial effect when used in combination with ECT<sup>11-14</sup> or insulin subcoma.<sup>15-19</sup>

4. The technic of its use, with indications and contraindications.<sup>20</sup>

5. Analysis of the nature of improvement, psychiatrically and psychologically, attending its use.<sup>1, 21</sup>

6. The physiologic denominators it has in common with other therapeutic modalities.<sup>22</sup>

7. Its place in a battery of biochemotherapeutic agents whose employment serially promises to increase the discharge rate from mental hospitals.

8. Its possible physiologic role in the interrelationship of the various hormones.<sup>23, 24</sup>

9. Finally, the broader implications to biology which its advent has brought forth leading to the development of a unifying concept regarding the etiology and pathogenesis of the psychoses and the psychoneuroses, providing a logical interpretation of pathogenesis in neuroendocrinologic terms.<sup>23, 24</sup>

\*Deceased.



## SCOPE OF THE PRESENT STUDY

The scope of the present report will be:

I. An analysis of historical factors of 63 Creedmoor (N. Y.) State Hospital patients who comprised the clinical population of an experimental histamine therapy and control ECT study which was previously reported;<sup>5, 11</sup>

II. An examination of the untoward reactions, morbidity and mortality; and

III. A presentation of the three-year follow-up of the foregoing patients.

I. *Historical Factors*

Data as to the previous history of the patients under study have been collated and studied under two major points:

A. Whether any of the groups under study had a high percentage of patients who had achieved convalescent status following therapy during prior hospitalizations and thus might be more likely to yield a higher rate of convalescent status.

B. Whether the groups were comparable as to duration of hospitalization prior to test therapy.

II. *Untoward Reactions, Morbidity and Mortality*

A review of the side reactions encountered during therapy has been undertaken as well as a study of the clinical record of patients who died during the follow-up period.

III. *Three-Year Follow-Up*

The course of the patients in the three-year follow-up period following termination of therapy has been reviewed to determine the following eight points:

A. Whether patients who had achieved some immediate improvement short of convalescent status during the therapy and arbitrary observation period of five weeks, continued their improvement to the attainment of convalescent status thereafter.

B. Whether patients who had not shown improvement during the period of the study subsequently attained convalescent status *without* further treatment.

C. Whether the inclusion of patients who had received treatment after the test therapies and had attained convalescent status in the subsequent three years significantly affects the evaluation of the therapeutic efficacy of the different test regimens.



D. Whether patients, previously unimproved after electric convulsive therapy (ECT) given during the same hospitalization as, but prior to, the study, were refractory\* to histamine therapy (HT) or post-histamine-ECT.

E. Whether histamine pre-treatment reduced the number of electric convulsive treatments required subsequently.

F. Whether the time required to attain convalescent status differed for the therapies studied.

G. Whether there was a difference in the relapse rate among the three groups.

H. The present-day status—approximately three years after therapy—of the 63 patients in both the experimental and control groups.

### *Clinical Material*

The 63 female patients who received the therapeutic regimen under study, fall into the following groups (see Table 1):

There were 38 in the original Histamine Group.

Twenty-five patients, from among the 33 of this group who did not attain convalescent status on a single course of histamine, received ECT and constituted the Post-Histamine-ECT Group.

Twenty-five patients comprised the Control ECT Group.

The psychiatric disorders represented in these groups, age distribution, and length of hospital residence prior to the therapy were analyzed and charted in two preceding papers.<sup>5,11</sup>

### *I. Historical Factors*

A. *Was any one of the test groups, though chosen at random, weighted with patients who were more likely than the average to respond to any therapy as evidenced by attaining convalescent status during previous hospitalization?*

The Post-Histamine-ECT Group included patients 53 per cent of whom had achieved convalescent status at some time prior to the test therapies. The Control ECT Group had 46 per cent of prior convalescences. The combined HT and Post-Histamine-ECT Group of 38 patients showed convalescent status achieved by 45 per cent at some time prior to the test; the final HT group of

\*Patients were designated refractory if they did not attain convalescent status after one course of HT with improvement starting either during four weeks of therapy or within one week following its termination.



Table 1. Improvement and Convalescent Status Rates During Test Period by Treatment Group and Diagnostic Category

Groups and Diagnostic Categories	No.	Improved*		Convalescent status	
		No.	Per cent	No.	Per cent
Histamine .....	38	10	26	5	13
Schizophrenic .....	(30)	(7)	(23)	(3)	(10)
Catatonic .....	21	5	24	1	5
Paranoid .....	9	2	22	2	22
Manic-depressive .....	(6)	(3)	(50)	(2)	(33)
Manic .....	5	2	40	1	20
Mixed .....	1	1	100	1	100
Involucional paranoid .....	(2)	(0)	(0)	(0)	(0)
Post-Histamine-ECT .....	25	12	48	4	16
Schizophrenic .....	(21)	(9)	(43)	(2)	(10)
Catatonic .....	16	9	56	2	13
Paranoid .....	5	0	0	0	0
Manic-depressive .....	(2)	(2)	(100)	(1)	(50)
Manic .....	2	2	100	1	50
Involucional paranoid .....	(2)	(1)	(50)	(1)	(50)
Control ECT .....	25	6	24	3	12
Schizophrenic .....	(23)	(4)	(17)	(2)	(9)
Catatonic .....	12	2	17	1	9
Paranoid .....	8	2	25	1	13
Hebephrenic .....	3	0	0	0	0
Manic-depressive .....	(2)	(2)	(100)	(1)	(50)
Combined Histamine and Post-Histamine-ECT .....	38	19	50	9	24
Schizophrenic .....	(30)	(13)	(43)	(5)	(17)
Catatonic .....	21	11	52	3	14
Paranoid .....	9	2	22	2	22
Manic-depressive .....	(6)	(5)	(83)	(3)	(50)
Manic .....	5	4	80	2	40
Mixed .....	1	1	100	1	100
Involucional paranoid .....	(2)	(1)	(50)	(1)	(50)

\*Improved refers to all patients who either went on to convalescent status or were benefited to some degree by therapy.

Per cent is presented for ease of reference only.

13 patients—20 per cent. From the point of view of this one factor alone, therefore, the two main groups, the combined Histamine and Post-Histamine-ECT Group, and the ECT Control Group, are comparable. See Table 2.



Table 2. Number of Patients in Each Group Treated Prior to Test Period and Number Who Achieved Convalescent Status Prior to Test Period

Group	(No.)	Total No. treated some time prior	No. patients achieving convalescent status	Therapy prior hospital.	No. attain. C. S.	Previous therapy current hospital.	No. attain. C. S.
Histamine .....	(13)	5	1 (20%)	2	1 (a)	4	0
Post-Histamine-ECT ...	(25)	17	9 (53%)	5	4 (b)	15	6 (d)
Combined (1 and 2)...	(38)	22	10 (45%)	7	5	19	6
Control ECT .....	(25)	13	6 (46%)	2	2 (c)	12	5 (e)

(a) Treated with metrazol. (b) Insulin and ECT—2; Insulin—1; Hydrotherapy and ECT—1. (c) Insulin—1; ECT—1. (d) Metrazol—1; ECT—4; Hydrotherapy and ECT—1. (e) ECT—4; Narcosynthesis—1.

B. *Were the three groups comparable as to the duration of hospitalization up to the administration of the test therapy?*

It can be readily seen from Table 3 that the experimental groups had more patients with shorter duration of hospitalization in the past than those in the ECT Control Group.

Table 3. Duration of Hospitalization Prior to Test Therapy and Attainment of Convalescent Status Immediately After Therapy (Percentages are given for ease of reference)

	a. HT 13+25=38	b. Post- HT-ECT 25	c. ECT control 25	a (13) and b (25) combined report 38
No. of patients				
6 mos. or less hosp.	19 (50%)	13 (52%)	7 (28%)	19 (50%)
Attained conv. status	4 (21%)	2 (15%)	1 (14%)	6 (32%)
6 mos. or more hosp.	19 (50%)	12 (48%)	18 (72%)	19 (50%)
Attained conv. status	1 (5%)	2 (17%)	2 (11%)	3 (16%)
Total immed. conv. status	5 (13%)	4 (16%)	3 (13%)	9 (24%)

However, a surprising fact is disclosed. On the basis of a higher convalescent status rate in the patients with shorter duration of hospitalization, as revealed by these data, one would have been led to expect that the ECT Control Group would not equal the Test Therapies Group in the prior rate of convalescent status. Yet this equality was indeed the case, as was shown in Table 2. Regardless of any statistical explanation, the presence of a larger proportion of patients with shorter periods of hospitalization in the Test Ther-



apies Group may be a weakness and should be avoided in future comparative studies. However, it is interesting to note that the outcome in the ECT Control Group was not significantly better in patients with short durations of hospitalization (1 of 7 = 14 per cent) than in those over six months (2 of 18 = 11 per cent). Without denying the role of this factor in the effect achieved, one can safely assume that it was not sufficient to negate the significance of the results obtained.

## II. *Untoward Reactions, Morbidity and Mortality*

Aside from the transient vascular response—a marked drop in systolic and diastolic pressure accompanied by tachycardia and flushing of face, arms and other parts of the body—no harmful effects could be attributed to the utilization of histamine in the manner described. However, during the three-year follow-up period, five patients of the 63 in the entire series, three in the experimental groups and two in the ECT Control Group, died. It seemed advisable to analyze the deaths to ascertain if there might be any relationship to therapy. Two of the three in the experimental groups were in the HT group and one in the Post-HT-ECT group.

Postmortem examination was carried out in only one of the patients (Post-HT-ECT, No. 25) by the medical examiner following a sudden death. A second sudden death (HT, No. 6) was not accepted by the medical examiner's office for necropsy. Of the other three patients, one (ECT No. 23) was a suicide and two (ECT No. 20 and HT No. 4) died after chronic illnesses. The case histories are summarized below:

*Case 1.* HT, No. 4, aged 38 at death; final diagnosis: chronic myocarditis, dementia præcox. This patient was extremely undernourished and emaciated upon admission to the hospital. During a previous hospitalization abroad, she had had insulin coma therapy. She was admitted to Creedmoor State Hospital on August 14, 1945. At this time, physical examination revealed only a poor nutritional status. In December 1945 the patient developed a right lower lobe pneumonia which responded to chemotherapy. Frequent feedings were given in order to achieve weight gain. Histamine therapy was instituted January 17, 1946 in an attempt to alleviate mental symptoms and was discontinued February 7, 1946. The next month, the patient was eating well and showed



some improvement following therapy. An x-ray plate taken March 22, 1946 was reported as showing both hilar shadows "moderately increased in size and density with evidence of fibro-calcified deposits. Linear pulmonic markings are accentuated in both lung fields due to chronic bronchitis. Apices and costophrenic angles are clear."

The following month, the patient was reported to be progressively weaker. She had developed a large abscess, which required incision, in the right buttock. Following transfer to the medical and surgical pavilion, she continued her downhill course. The terminal note stated that the patient had cyanosis, dyspnea and rapid pulse. She died on May 18, 1946—three months after termination of histamine therapy. Permission was not granted for autopsy and the patient was certified as having died of chronic myocarditis and dementia præcox.

COMMENT: Since this death occurred three months after the discontinuance of histamine therapy, it is surely not attributable to acute histamine toxicity. It is unfortunate, however, that an autopsy was not available in this case to check particularly on the myocardial damage. However, it is important to note that the clinical findings did not implicate the heart prior to the terminal state.

Case 2. HT, No. 6, aged 26 at death; final diagnosis: dementia præcox, catatonic type, 10 years; and acute excitement, two days. This patient was admitted on October 14, 1944. HT was begun January 17, 1946 and terminated February 8, 1946. ECT was administered from April 15, 1946 to July 22, 1946, for a total of 32 grand mal convulsions. Thereafter, she received ECT on occasion, as deemed necessary, totaling 45 convulsions. The last convulsive treatment was given on July 9, 1947. On August 7, 1947, at 2:30 a. m., after two days of acute excitement, she was observed to be cyanotic. Her pulse was weak and there was no evidence of injury. Her temperature was 99.8. The patient died at 4:30 a. m. The medical examiner waived autopsy and in the absence of consent, it was not performed by the hospital staff.

COMMENT: Here again, it is difficult to relate the death of the patient to prior therapy. Histamine treatment had been completed six months previously, electric convulsive therapy one month pre-



viously—both without evident incident or disturbance. Acute excitement was the only untoward event directly preceding the mortality.

*Case 3.* Post-HT-ECT, No. 25, aged 35 at death; final diagnosis: aspirated stomach contents into lungs, asphyxia; schizophrenia. This patient was admitted October 25, 1944. HT was instituted January 15, 1946 and ECT was administered between February 9, 1946 and March 9, 1946, for a total of 23 grand mal convulsions and 1 petit mal reaction. Subsequently, beginning August 19, 1946, and until November 20 of the same year, the patient had ECT, 19 convulsions. On November 25, 1946 she was found in a comatose state from which she could not be aroused and died one hour later.

COMMENT: The certified diagnosis of asphyxia caused by aspiration in this case was based on the pathological findings of a postmortem examination by the medical examiner.

*Case 4.* ECT, No. 20, aged 22 at death; final diagnosis: pulmonary abscess, dementia præcox, hebephrenic type. This patient was admitted September 15, 1945. She was included in the ECT-Control Group and received a course of 21 grand mal convulsions between March 15, 1946 and May 8, 1946 without improvement. Between July 10, 1946 and May 22, 1947, she received additional ECT, 44 convulsions, without improvement.

On March 5, 1947, during the period of another course of ECT, the patient was x-rayed because of a left lower lobe pneumonia diagnosed on physical examination. The roentgenologist reported "an area of infiltration at left base suggesting acute pneumonia." On April 7, 1947, a second x-ray was negative. However, the patient later developed fever again, and an x-ray on June 9, 1947 revealed "consolidation of the left central and left lower lung fields suggesting a possible pneumonia." On June 25, 1947 there was no change in radiological findings. The following week, it was decided to treat the patient as a case of lung abscess. She maintained an elevated temperature and appeared acutely ill in spite of penicillin therapy. An x-ray on July 14 showed "an increase in consolidation of left lower lung field." By the following week, the patient had become productive of large amounts of foul sputum necessitating postural drainage. She continued progressively downhill and died on August 4, 1947 following a violent coughing paroxysm. An autopsy could not be performed.



COMMENT: The possibility cannot be excluded that, sometime during her second ECT course, this patient aspirated a foreign body and developed a lung abscess, although no indication of such an occurrence was noted in the chart.

Case 5. ECT, No. 23, aged 34 at death; final diagnosis: manic-depressive, depressed; suicide seven months after discharge. This patient was admitted December 22, 1945. She was given ECT as one of the ECT Control Group between March 20, 1946 and March 27, 1946 with marked improvement. Convalescent status was granted May 25, 1946 and she was discharged the following year. On December 21, 1947 she committed suicide.

### III. *Three-Year Follow-Up*

In preparing this study, criteria previously defined<sup>1,2</sup> were applied unless otherwise stated in the corresponding section under review. These were: (1) Improvement must have been attained during the four weeks of therapy or within one week after termination of therapy; and (2) convalescent status, i. e., sufficient recovery to warrant release by the hospital staff, was usually accompanied by elimination of the major presenting symptomatology.

During the follow-up period, the patients were dispersed to different wards and different services, in the usual course of the hospital's routine, and thus all patients were subject to similar random chances. The therapeutic procedures applied and observations made during this period were those usual for the hospital.

A. *Did patients who had achieved some immediate improvement during the test period, continue improving until they attained convalescent status?*

Convalescent status was attained by five additional patients who had previously been considered as only improved during or within one week following termination of the therapy but who had received no further treatment. These patients had been previously classified merely as benefited because the arbitrarily set "experimental period" had terminated. Since these results were probably related to therapy, the data are herewith included, necessitating correction of the original figures.



## I. Histamine Group.\*

Improvement—54 per cent.\*\*

Convalescent status—38 per cent, now corrected to 46 per cent because of an additional case:

HT, No. 2, a manic-depressive, manic, aged 40, with a hospital residence of nine years,† received 26 histamine treatments over a period of 49 days, with immediate improvement, and ultimately achieved convalescent status nine months after termination of HT.

## II. Post-Histamine-ECT Group.

Improvement—48 per cent.

Convalescent status—16 per cent, now corrected to 28 per cent because of three additional cases:

(a) Post-HT-ECT, No. 5, a catatonic schizophrenic, aged 24, with a hospital residence of two months, improved with 26 ECT and 73 HT treatments in a period of 128 days and achieved convalescent status two months after termination of the combined therapies.

(b) Post-HT-ECT, No. 16, a catatonic schizophrenic, aged 44, with a hospital residence of six months, improved following 24 grand mal seizures and one petit mal seizure (ECT), and 48 histamine treatments, all over a period of 73 days. She achieved convalescent status three and one-half months after termination of therapy.

\*For purposes of the three-year follow-up study, the HT Group has been limited to the 13 patients who had HT only during the test period.

\*\*The results when calculated on the basis of all 38 patients in the original Histamine Group would show the following immediate results and subsequent results without therapy:

§

	Immediate	A. Corrected by improved patients who subsequently attained convalescent status without further therapy	B. Corrected by unimproved patients who subsequently improved and attained convalescent status without further therapy
	Per cent	Per cent	Per cent
Improvement	26	26	32
Convalescent status (C. S.)	13	16	21

†Hospital residence is calculated from admission to the date of administration of test therapy to the patient.



(c) Post-HT-ECT, No. 16, a manic-depressive, manic, aged 34, with a hospital residence of one year and 10 months, improved with 14 electric convulsive treatments and 45 histamine treatments in a period of 56 days, and achieved convalescent status four months after termination of therapy.

### III. Control ECT Group.

Improvement—24 per cent.

Convalescent status—12 per cent, now corrected to 16 per cent because:

(a) ECT, No. 7, a manic-depressive, mixed, aged 41, with a hospital residence of three years, two and one-half months, improved with 19 electric convulsive treatments in a period of 57 days and achieved convalescent status three months after termination of therapy.

### IV. Histamine and Post-Histamine-ECT Groups Combined.

Improvement—50 per cent.

Convalescent status—24 per cent, now corrected to 34 per cent.

COMMENT: The writers believe that the convalescent status results originally reported as immediate, following an arbitrary period of four weeks of the test therapies, should now be adjusted to include those patients who improved in the study and then subsequently continued to convalescent status without further therapy. Their inclusion is in accord with the original criterion, because improvement had started during the arbitrary period of four weeks of therapy and one week beyond its completion, and the eventual attainment of convalescent status can thus be assumed to be related to the test therapy applied.

Inclusion of the five patients in this category of delayed convalescent status (HT Group, 1; Post-Histamine-ECT Group, 3; and ECT Control Group, 1) raises the convalescent status rate of the Post-Histamine-ECT Group from 16 per cent to 28 per cent—or almost double that of the ECT Control Group, 16 per cent; while the HT and Post-Histamine-ECT Groups combined had a convalescent status rate of 34 per cent, or more than double the 16 per cent ECT Group rate. The entire original HT Group of 38 patients (computing only the results of HT alone) and the ECT Control Group of 25 patients showed approximately the same rates, each 16 per cent.



B. *Did patients who had not evidenced gross signs of improvement during the test period subsequently attain convalescent status without further treatment?*

Convalescent status was subsequently achieved by four patients who had *not* shown any striking benefit from the test therapies and who had *not* received further treatment. These results may or may not have been related to therapy, but the inclusion of this group as having actually benefited would bring about the following percentile changes:

#### I. Histamine Group.

Improvement—69 per cent (from 54 per cent).

Convalescent status—46 per cent, now corrected to 62 per cent because:

(a) HT, No. 3, a paranoid schizophrenic, aged 37, with a hospital residence of five years, eight months, received 11 histamine treatments without improvement over a period of 10 days and subsequently achieved convalescent status 13 months after the termination of therapy.

(b) HT, No. 9, a manic-depressive, manic, aged 26, with a hospital residence of one year, one month, received nine histamine treatments over a period of 11 days without improvement and subsequently achieved convalescent status four months after termination of the therapy.

#### II. Post-Histamine-ECT Group.

Improvement—52 per cent (from 48 per cent).

Convalescent status—28 per cent, now corrected to 32 per cent because:

Post-HT-ECT, No. 17, a paranoid schizophrenic, aged 38, with a hospital residence of 11 months, was unimproved after seven electric convulsive treatments and 70 histamine treatments, in a period of 146 days; she achieved convalescent status one month after termination of therapy.

#### III. Control ECT Group.

Improvement—28 per cent (from 24 per cent).

Convalescent status—16 per cent, now corrected to 20 per cent because:



ECT, No. 16, a catatonic schizophrenic, aged 36, with a hospital residence of one year, two months, was unimproved after 19 electric convulsive treatments in a period of 54 days but subsequently achieved convalescent status two years after termination of therapy.

#### IV. Histamine and Post-Histamine-ECT Groups Combined.

Improvement—56 per cent (from 50 per cent).

Convalescent status—34 per cent, now corrected to 42 per cent.

COMMENT: Since improvement after ECT may begin later than one week following termination of treatment, the inclusion of such results was considered advisable in the comparative rating. Accordingly, the data previously revised under the preceding observation, were again adjusted for four patients who subsequently achieved convalescent status. Of these, two were in the HT Group and one each in the other two groups.

In the comparative ratings, the Post-Histamine-ECT Group remained ahead of the ECT Control Group in the attainment of convalescent status—32 per cent, as compared to 20 per cent, whereas the rate of 21 per cent of the original Histamine Group of 38 patients (results from HT alone) was essentially not different from that of the control group.

*C. Did patients who received additional treatment, after conclusion of the test therapy and the immediate follow-up, attain convalescent status in the subsequent three years, thereby affecting the evaluation of therapeutic efficacy of the different regimens studied?*

In the subsequent three years 12 more patients left on convalescent status after receiving additional therapy.\*

#### I. Histamine Group.

Improvement—77 per cent (from 69 per cent).

Convalescent status—62 per cent, now corrected to 69 per cent because:

HT, No. 13, a catatonic schizophrenic, aged 23, with a hospital residence of 10 and one-half months, unimproved after 31 histamine treatments over a period of 23 days, subsequently achieved convalescent status 11 months after the start of HT, and three months after the termination of an additional course of 32 electric convulsive treatments.

\*Additional therapy was ECT in every case except one, in which it was hydrotherapy.



## II. Post-Histamine-ECT Group.

Improvement—64 per cent (from 52 per cent).

Convalescent status—32 per cent, now corrected to 60 per cent because:

(a) HT-ECT, No. 12, a catatonic schizophrenic, aged 29, with a hospital residence of one month, improved on 10 electric convulsive treatments and 18 histamine treatments, in a period of 43 days. She achieved convalescent status six and one-half months after the start of HT and four days after the termination of 10 additional electric convulsive treatments.

(b) HT-ECT, No. 4, a catatonic schizophrenic, aged 22, with a hospital residence of one month, improved on 42 grand mal and one petit mal electric convulsive treatments, after 50 histamine treatments in a period of 117 days. She achieved convalescent status five months after the start of HT, following hydrotherapy.

(c) HT-ECT, No. 3, a catatonic schizophrenic, aged 22, with a hospital residence of one month, improved on 24 electric convulsive treatments after 28 histamine treatments in a period of 142 days. She achieved convalescent status nine and one-half months after the start of HT and one month after the termination of 35 additional electric convulsive treatments.

(d) HT-ECT, No. 20, a catatonic schizophrenic, aged 41, with a hospital residence of three and one-half months, was unimproved by 14 grand mal and two petit mal electric convulsive treatments after 11 histamine treatments in a period of 50 days. She subsequently achieved convalescent status a year after the start of HT, and four months after termination of 15 additional electric convulsive treatments.

(e) HT-ECT, No. 2, a catatonic schizophrenic, a postpartum case, aged 30, with a hospital residence of four months, improved on nine grand mal and one petit mal electric convulsive treatments after 45 histamine treatments in a period of 56 days. She subsequently achieved convalescent status one year after the start of HT and two months after the termination of 52 additional electric convulsive treatments.



(f) HT-ECT, No. 8, a catatonic schizophrenic, aged 34, with a hospital residence of three years, was unimproved by 18 grand mal and one petit mal electric convulsive treatments and 30 histamine treatments in a period of 178 days; but subsequently achieved convalescent status nine months after the start of HT and immediately after the termination of 19 additional electric convulsive treatments.

(g) HT-ECT, No. 9, an involutional paranoid patient, aged 50, with a hospital residence of four years and five months, was unimproved by 14 grand mal and five petit mal electric convulsive treatments and 39 histamine treatments in a period of 124 days; but she subsequently achieved convalescent status one year and five months after the start of HT, and following more than 17 additional electric convulsive treatments.

### III. Control ECT Group.

Improvement—44 per cent (from 28 per cent).

Convalescent status—20 per cent, now corrected to 36 per cent because:

(a) ECT, No. 19, a catatonic schizophrenic, aged 22, with a hospital residence of one month, was unimproved by 14 electric convulsive treatments in a period of 40 days, but subsequently achieved convalescent status two years and two months after the start of therapy and four months after an additional 135 electric convulsive treatments.

(b) ECT, No. 9, a catatonic schizophrenic, aged 27, hospitalized for two months, was unimproved by 20 electric convulsive treatments in a period of 75 days. She subsequently achieved convalescent status nine months after the start of therapy and one and one-half months after the termination of 40 more electric convulsive treatments.

(c) ECT, No. 8, a catatonic schizophrenic, aged 29, a post-partum case, with a hospital residence of one year and four months, was unimproved by 17 electric convulsive treatments in a period of 45 days, but subsequently achieved convalescent status nine months after the start of therapy and two months after termination of an additional course of 34 electric convulsive treatments.

(d) ECT, No. 25, a paranoid schizophrenic, aged 19, with a hospital residence of one month, was unimproved by 20 elec-



Table 4. Improvement Rates and Convalescent Status Rates

Group		Immediate				Including A.				Including B.				Including C.			
		Improved		C. S.		Improved		C. S.		Improved		C. S.		Improved		C. S.	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
(Histamine)*	(38)	(10)	(26)	( 5)	(13)	(10)	(26)	(6)	(16)	(12)	(32)	( 8)	(21)				
Histamine	(13)	7	54	5	38	7	54	6	46	9	69	8	62	10	77	9	69
Post-Histamine-ECT	(25)	12	48	4	16	12	48	7	28	13	52	8	32	16	64	15	60
Control ECT	(25)	6	24	3	12	6	24	4	16	7	28	5	20	11	44	9	36
Combined Histamine and Post-Histamine ECT	(38)	19	50	9	24	19	50	13	34	22	58	16	42	26	68	24	63

A.—Patients who showed immediate improvement and subsequently attained convalescent status *without* further treatment.

B.—Patients who had not evidenced gross signs of improvement during or within one week after test therapy but subsequently attained convalescent status *without* further treatment.

C.—Patients who after receiving further treatment—ECT in all but one case—subsequently attained convalescent status.

\*—38 patients in original Histamine Group.



tric convulsive treatments in a period of 48 days, but subsequently achieved convalescent status four and one-half months after the start of therapy and one and one-half months after termination of an additional 10 grand mal and one petit mal electric convulsive treatments.

#### IV. Histamine and Post-Histamine-ECT Combined.

Improvement—68 per cent (from 56 per cent).

Convalescent status—42 per cent, now corrected to 63 per cent.

The data in reply to questions A, B and C are summarized in Table 4.

*D. Were patients previously unimproved by ECT (during the hospitalization of the test period) also refractory to HT or Post-Histamine-ECT?*

Patients who previously had been refractory to ECT were not necessarily refractory to HT or to post-histamine-ECT. Convalescent status was attained by five of eight such patients after HT or post-histamine-ECT was administered. Of these five, one received no further therapy, and four received subsequent ECT after termination of the test period. Of four patients, in the Control ECT Group, who were previously refractory to this therapy, one, after no immediate improvement, achieved convalescent status two years later. Thus, previous refractoriness to ECT might have been broken in a few cases by the course of HT or might have yielded to a spontaneous remission.

(a) HT, No. 8, a paranoid schizophrenic, aged 33, with a hospital residence of four months, was unimproved following ECT, 12 grand mals and 2 petit mals, received HT alone with improvement within a week following therapy, and achieved convalescent status six months after the start of HT. The patient returned 31 months later and again attained convalescent status after four months without further therapy.

(b) HT, No. 13, a catatonic schizophrenic, aged 23, with a hospital residence of 10 and one-half months, was unimproved following ECT (40 grand mals and three petit mals) and HT alone. She received a subsequent ECT course of 32 grand mals and achieved convalescent status 11 months after the start of HT.



(c) HT-ECT, No. 2, a catatonic schizophrenic, a post-partum patient, aged 30, with a hospital residence of four months, was unimproved following ECT (14 grand mals and one petit mal). She was benefited on post-histamine-ECT, received a subsequent ECT course of 52 grand mals, and achieved convalescent status 12 months after the start of HT.

(d) HT-ECT, No. 9, an involutional paranoid patient, aged 50, with a hospital residence of four years and five months, was unimproved following prior ECT (10 grand mals and 10 petit mals) and post-histamine-ECT. She received a subsequent ECT course of 12 grand mals and five petit mals and achieved convalescent status 17 months after the start of HT.

(e) HT-ECT, No. 20, a catatonic schizophrenic, aged 41, with a hospital residence of three and one-half months, was unimproved following prior ECT (seven grand mals and seven petit mals) and 11 histamine treatments. She remained unimproved on ECT (14 grand mals and two petit mals), achieving convalescent status 12 months after the start of HT, four months after termination of 15 grand mal electric convulsive treatments.

COMMENT: Evaluation of the results of all patients, including those who received further therapy, was undertaken to determine whether subsequent events altered the relative benefits of the procedure studied. No alteration was found.

Twelve patients achieved convalescent status following additional therapy—which in every case but one (hydrotherapy) was ECT. Of these, one was in the HT Group, seven in the Post-Histamine-ECT Group and four in the ECT Control Group. Thus, in the Post-Histamine-ECT Group 64 per cent showed improvement, and 60 per cent attained convalescent status; while in the ECT Control Group, 44 per cent showed improvement, and 36 per cent attained convalescent status.

The results analyzed here seemed to point strongly to an added advantage conferred by HT. Not only was it effective by itself, but also it seemed to have a potentiating effect on ECT, resulting in a far greater percentage of improved and convalescent status patients when given combined with ECT. In addition, it appeared that patients previously unimproved after ECT during the hospitalization of the test period, did not necessarily fail to respond



to either HT or Post-Histamine-ECT. On the contrary, they seemed to be assured a better response following HT and fared five times better than patients who received additional ECT without histamine. (See Table 5.)

Furthermore, study of the effect of additional courses of ECT on patients previously refractory to this therapy—as in those unimproved in the ECT Control Group—revealed that of 18 patients, four (22 per cent) attained convalescent status. This does not compare favorably with the attainment of convalescent status by three of four patients in the Post-Histamine-ECT Group who were unimproved with prior ECT.

*E. Did histamine pre-treatment reduce the number of electric convulsive treatments required subsequently to achieve convalescent status?*

No definitive conclusion can be drawn from the results when they are analyzed to determine the number of electric convulsive treatments required for attainment of convalescent status. Therapeutic courses of eight patients (Post-HT-ECT, Nos. 1-8) were compared as to the numbers of convulsions required to attain convalescent status before histamine; with histamine; and after histamine. In addition, the therapy of two patients in the ECT Control Group and one in the Histamine Group was reviewed. Three of eight patients (Post-HT-ECT, Nos. 4, 5, 7) required fewer convulsions during or after the test period. (See Table 6.)

*F. Was there a difference in the time required by patients in each group to attain convalescent status?*

The time elapsing between the institution of test therapy and the attainment of convalescent status is presented in Table 7. The HT Group had patients leave on convalescent status four to four and one-half months after initiation of therapy, one month later than the other two groups. However, no definite conclusion can be drawn from so small a variation.

*G. Was there any difference in the relapse rate of the three groups?*

The courses of the patients in the three groups who achieved convalescent status following the test therapies are recorded in Table 8. Of five patients in the HT Group, three relapsed; and, of these, two again attained convalescent status; one with and one



Table 5. Effect of Histamine on Patients Previously Refractory to ECT; Comparison with Effect of Additional Course of ECT in Control Group

Group and patient	Diagnosis	Prior ECT, Current Hosp.		Result Prior ECT	Test therapy	Result	Supplement ECT			No. Pts. Refrac. No. Pts. Attain. No. Pts. Unimp.					
		G. M.	P. M.				G. M.	P. M.	Result	prior ECT	C. S.	Unimp.			
Histamine-(HT)															
H 6	S.—Cat.	21	..	U	HT	U	77	..	U	..	4	2	2		
H 10	S.—Cat.	15*	..	U	HT	U	38	..	U	..	..	..	..		
H 13	S.—Cat.	40	3	U	HT	U	32	..	CS	..	..	..	..		
H 8	S.—Par.	12	2	U	HT	CS	..	..	..	..	..	..	..		
Post-HT-ECT															
HC 2	S.—Cat. (PP)	14	1	U	G. M.	P. M.	9	1	B	52	..	CS	4	3	1
HC 20	S.—Cat.	7	7	U	11	2	U	26	..	CS	..	..	..	..	
HC 25	S.—Par.	37	10	U	23	1	U	19	..	U	..	..	..	..	
HC 9	Inv. Par.	10+	10+	U	14	2	U	12	5	CS	..	..	..	..	
ECT Control															
C 4	S.—Cat.	15	1	U	8	..	U	191	..	U	..	4	1	3	
C 5	S.—Cat.	..	..	U	6	..	U	125	..	U	..	..	..	..	
C 16	S.—Cat.	20	..	U	19	..	U	..	..	CS**	..	..	..	..	
C 14	S.—Par.	38	10	U	20	2	U	15	..	U	..	..	..	..	

\*Patient also had had 17 grand mal convulsions induced by metrazol.

\*\*This patient was unimproved immediately after control ECT but subsequently improved and attained convalescent status two years later.

Group abbreviations:

H—Histamine (HT).

HC—Post-Histamine-ECT.

C—ECT control.

S.—Cat.—Schizophrenia, catatonic type.

S.—Par.—Schizophrenia, paranoid type.

Inv. Par.—Involutional psychosis, paranoid type.

G.M.—Grand mal.

P. M.—Petit mal.

PP—Postpartum.

U—Unimproved.

CS—Convalescent status.



without subsequent therapy. Of four patients in the Post-Histamine-ECT Group, three relapsed; and, of these, two again attained convalescent status with subsequent treatment; and one without it. None of the three patients in the ECT Control Group relapsed.

Table 6. Number of Grand Mal Convulsions Administered to Patients Achieving Convalescent Status Before, During and After Test Therapy Period

Group and Patient	No. G. M. Before Test Period → Conv. Status	No. G. M. During Test Period and Result	No. G. M. After Test Period → Conv. Status
Histamine			
1. H 13	**	—	32
Post-Histamine-ECT			
1. HC* 5	12	24 U	16+
2. HC 20	—	11 U	26
3. HC 2	—	9 U	32
4. HC 8	64	18 U	19
5. HC 14	10	8 CS	37†
6. HC 17	19	7 U—CS†	—
7. HC 1	10	11 CS	9‡
8. HC 21	6***	2 CS	—
ECT Control			
1. C 10	8	17 CS	—
2. C 23	5	5 CS	—

\*HC—Post-HT-ECT.

\*\*Achieved CS on HT alone.

†Without further therapy. Improvement was noted more than one week after termination of treatments. Because of the criterion previously set, this patient was not included in the original group achieving convalescent status.

‡After relapse.

U—unimproved.

\*\*\*With insulin.

CS—convalescent status.

Thus, there was a difference in the relapse rate of the patients in the three groups who immediately achieved convalescent status. The clinical course of some of the patients in the HT Group seemed to support an earlier observation on the possible need of maintenance histamine therapy in selected cases.\* Although patients in the Post-Histamine-ECT Group who went on to convalescent status immediately following test therapy indicated the greatest likelihood to relapse, all of them subsequently did achieve "permanent" convalescent status. There were no relapses in the ECT

\*This will be discussed more fully in subsequent papers on histamine therapy of non-hospitalized psychotics and psychoneurotics.



Table 7. Time in Months Required from Institution of Test Therapy to Attainment of Convalescent Status

Months	2-2½	3-3½	4-4½	5-5½	6-6½	9-9½	11-12	13-15	16-18	24-26	
<i>Histamine</i> (13 pts.)											
Test therapy .....	1	1	2		1						} Conv. status 9 (69%)
Subsequent without therapy			1				1	1			
Subsequent with therapy...							1				
<i>Post-Histamine-ECT</i> (25 pts.)											
Test therapy .....	2	2									} Conv. status 14 (56%)
Subsequent without therapy					3						
Subsequent with therapy...				1	2	2	1		1		
<i>ECT Control</i> (25 pts.)											
Test therapy .....	2	1									} Conv. status 9 (36%)
Subsequent without therapy										1	
Subsequent with therapy ...			1	1		2				1	



Control Group. The regrouping of the data relating to this aspect of the clinical course of the three groups of patients over the three-year period is included in Table 8.

Table 8. Course of Patients Who Attained Convalescent Status Immediately Following Test Therapy

Group	No. conv. status	No. relapsed	C. S. with- out subs. treat- ment	C. S. with subs. treat- ment	In hospital	"Perma- nent" C.S.
Histamine	5	3	1	1	1	4/5
Post-Histamine-ECT	4	3	1	2	0	4/4
ECT control	3	0	0	0	0	3/3

H. *What is the present-day status—three years after therapy—of the 63 patients in the experimental and control groups?*

At the end of the three-year period, of the 63 patients studied, 27 were out of the hospital, either on convalescent status or discharged. Of these: (a) Seven patients were from the Histamine Group of 13; (b) 14 were from the Post-Histamine-ECT Group of 25 (56 per cent); and (c) six were from the ECT Control Group of 25 (24 per cent).

The immediate and three-year follow-up status of all the patients and the relationship of attainment of convalescent status and duration of hospitalization are charted in Table 9.

It must again be noted that 42 patients had subsequently received therapy over the three-year period, while three patients of the HT Group, two of the Post-Histamine-ECT Group and three of the ECT Control Group maintained their status or regained it without further therapy. This also indicated better results with histamine either singly or in combination with other therapy.

### SUMMARY

The histories of 63 hospitalized female psychotics with schizophrenic, manic-depressive and involutional disorders—treated with histamine alone, histamine followed by ECT, and by ECT alone as a control group, are reviewed from the time of their first hospital admissions. A three-year follow-up on the subsequent course of the patients treated with histamine and Post-Histamine-ECT as well as the ECT control patients is presented. The findings revealed that:



1. The HT Group and Post-Histamine-ECT Group combined showed improvement in 68 per cent and convalescent status in 63 per cent, taking into account patients who subsequently attained improvement over the three-year period, either with or without further therapy. The ECT Control Group had improvement in 44

Table 9. Immediate and Three-Year Follow-up Status of 63 Patients in Test Groups: Histamine (HT), Post-Histamine-ECT and ECT Control

Therapy	a. HT	b. Post-HT-ECT	c. ECT Control	a. and b. Comb. Results
No. of patients	38—13*	25	25	38
1. Immediate C. S. and percentage	5 (13%)**	4 (16%)	3 (12%)	9 (24%)
<i>Three-year Follow-up</i>				
2. No. patients with 6 mos. or less hospitalization and percentage	6 (46%)†	13 (52%)	7 (28%)	19 (50%)
3. No. on C. S.	4	9	3	13
4. No. patients with over 6 mos. hospitalization and percentage	7 (54%)†	12 (48%)	18 (72%)	19 (50%)
5. No. on C. S.	3	5	3	8
6. Total No. patients out of hospital (inc. 3. and 5.) and percentage	7 (54%)†	14 (56%)	6 (24%)	21 (55%)

\*The original group consisted of 38 patients, of whom 25 went on to ECT (b.) leaving a total of 13 patients who received HT alone.

\*\*Calculated on the basis of the immediate group of 38 patients.

†Calculated on the basis of the resultant group of 13 patients.

per cent and convalescent status in 36 per cent; the Post-Histamine-ECT Group alone, showed improvement in 64 per cent and convalescent status in 60 per cent.

2. Patients previously refractory to ECT during the same hospitalization were found responsive to HT, Post-Histamine-ECT or to ECT alone. However, five of eight ECT refractory patients (63 per cent) in the combined test groups (HT plus Post-Histamine-ECT) attained convalescent status, with another course of ECT, whereas of four in the ECT Control Group, only one subsequently achieved convalescent status and did so two years later. Furthermore, of 18 patients previously refractory to ECT (in



prior admissions) in the Control Group, only four (22 per cent) finally attained convalescent status with a second course of ECT (Table 10).

3. Though the groups were comparable as to diagnostic classification, age groups, previous therapy and even prior attainment of convalescent status, *they were not wholly comparable as to duration of hospitalization*. The Control Group, on analysis, revealed a higher percentage of patients with over six months or one year of hospitalization. This is a weakness in the study which may not be significant since convalescent status in the ECT Control Group is approximately the same in those under and over six months of hospitalization (Table 11).

4. The HT Group had the highest relapse rate while the ECT Control Group had the lowest. This corroborated an earlier observation of the possible need for maintenance HT.

Table 10. Results of Subsequent Course of ECT in ECT Control Patients Refractory During Test Period

Patient number	Diagnosis	ECT Control			Subsequent ECT		
		G. M.	P. M.	Result	G. M.	P. M.	Result
C* 4	DPC	20**	..	U	179	..	U
C 5	DPC	17**	..	U	108	..	U
C 8	DPC, PP	17	..	U	34	..	CS
C 9	DPC	20**	..	U	40	..	CS
C 13	DPC	21**	..	U	33	..	U
C 19	DPC	14	..	U	135	..	CS
C 21	DPC	19**	..	U	19	..	U
C 22	DPC, PP	24	..	U	28	..	U
C 24	DPC	21**	1	U	17	..	U
C 1	DPP	35	..	U	5	..	U
C 2	DPP, PP	15	1	U	46	..	U
C 11	DPP	20**	..	B	60	..	U
C 14	DPP	20	2	U	15	..	U
C 15	DPP	18**	..	U	50	..	U
C 17	DPP	15	2	U	22	..	U
C 25	DPP	20	1	U	10	..	CS
C 18	DPH	23	..	U	44	..	U
C 20	DPH, PP	16	..	U	44	..	U

\*ECT Control Group

\*\*ECT Control course completed after termination of test period

B—Benefited

U—Unimproved

CS—Convalescent status

DPC—Schizophrenia, Catatonic

DPH—Schizophrenia, Hebephrenic

DPP—Schizophrenia, Paranoid

PP—Post-partum



Table 11  
Duration of Hospitalization Prior to Test Therapy and the Achievement of Convalescent Status

In Patients Hospitalized Less or More Than 6 Months

	Histamine alone						Post-Histamine-ECT						ECT Control						Comb. HT plus Post-Histamine-ECT					
	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.
Less than 6 months	6	4	..	..	..	4	13	2	2	..	5	9	7	1	..	..	3	4	19	6	2	..	5	13
Over 6 months	7	1	1	2	1	5	12	2	1	1	2	6	18	2	1	1	1	5	19	3	2	3	3	11
Total	13	5	1	2	1	9	25	4	3	1	7	15	25	3	1	1	4	9	38	9	4	3	8	24

In Patients Hospitalized Less or More Than 12 Months

	Histamine alone						Post-Histamine-ECT						ECT Control						Comb. HT plus Post-Histamine-ECT					
	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. B.	C. S. with later Rx	C. S. with later Rx	C. S. with later Rx	Total C. S.
Less than 12 months	7	4	..	..	1	5	14	2	2	1	5	10	11	2	..	..	3	5	21	6	2	1	6	15
Over 12 months	6	1	1	2	..	4	11	2	1	..	2	5	14	1	1	1	1	4	17	2	2	2	2	9
Total	13	5	1	2	1	9	25	4	3	1	7	15	25	3	1	1	4	9	38	9	4	3	8	24

C.S.—Convalescent status

B.—Benefited during test period

U.—Unimproved during test period.



5. Three years after the test period, 27 of all 63 patients were found to be either on convalescent status or discharged. Analysis showed that seven were from the HT Group, 14 from the Post-Histamine-ECT Group, and six from the ECT Control Group.

### CONCLUSIONS

On the basis of these data, and within the limitations of the series, this three-year follow-up confirms the findings of the original observation period, to the effect that:

1. Nonconvulsive biochemotherapy by itself achieves results in hospitalized (schizophrenic, manic-depressive and involutional) psychotics comparable to or better than ECT.

2. Nonconvulsive histamine biochemotherapy seems to have a potentiating effect on ECT given subsequently to histamine-refractory patients.

3. A regimen of nonconvulsive histamine biochemotherapy, followed by ECT for those not attaining convalescent status, may double the number of mental hospital patients now attaining convalescent status with ECT, if the results in this study are achieved with larger numbers of patients.

4. The beneficial effects of ECT cannot be attributed to histamine release alone if the data reported herein are borne out by subsequent large scale studies, though histamine release may be one factor in a complex phenomenon producing improvement.

*In addition, one must conclude that:*

5. Since ECT-refractory patients respond better to Post-Histamine-ECT than to histamine alone, or to a second course of histamine, patients previously refractory to ECT should receive histamine pre-treatment if ECT is to be prescribed.

6. Large scale studies with histamine alone and in combination with other modalities are desirable. Further study of this and other biochemotherapeutic regimens will contribute to, and in turn will itself be further advanced by research on, the etiology and pathogenesis of mental disease.

A large series of non-hospitalized psychotics and psychoneurotics treated with nonconvulsive histamine biochemotherapy; a series treated in conjunction with ECT and subcoma insulin; a study of effects on direct eosinophile counts; changes induced by histamine therapy as revealed in the Rorschach and other projec-



tive tests; and details as to technique with special considerations respecting peptic ulcer, hay fever and asthma—will be presented in subsequent papers. A working hypothesis presenting a phylogenetic concept and rationale in which nonconvulsive histamine biochemotherapy is related rationally to other indicated procedures will be offered in a forthcoming report.

#### ACKNOWLEDGMENT

The authors gratefully acknowledge the encouragement and assistance of Dr. H. A. LaBurt, senior director, Creedmoor State Hospital and of Dr. Co Tui, associate professor, experimental surgery, New York University, College of Medicine. Appreciation is also expressed for the critical review of the manuscript by Drs. Co Tui and Marvin Weinberg. The assistance of Sydel Braverman in preparation of the manuscript is noted. The expenses of the study were defrayed by a grant made in the memory of Isaac Sackler.

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## FACTORS INVOLVED IN THE GENESIS AND RESOLUTION OF NEUROTIC DETACHMENT

BY MONTAGUE ULLMAN, M. D.

Although the term "detachment" is in fairly common use, both descriptively and dynamically, its precise implications still elude a complete understanding. It is the object of this paper to attempt a close scrutiny of this particular defensive reaction in a patient who presents many of the typical problems encountered.

Many terms are used in conjunction with and in close relation to detachment. A detached person is said to rely heavily on the mechanism of withdrawal from reality. Depending on the person and the situation, he may be regarded as distant, aloof, untouched, preoccupied, removed, or remote. When there is greater affective coloring, his detachment may lurk under the guise of arrogance, cynicism, superiority, or snobbishness. Autism and dissociation are other terms that are related to the problem. As considered here, detachment is a way of reacting to one's environment, based on the illusion that it is both possible and necessary to disregard the real needs of people and to exist in a state of isolated independence. Fundamentally, it is an attitude toward the self, projected onto others, of extraordinary disregard and unconcernedness. This definition can be made more specific by a comparison of detachment with other neurotic devices. Any neurotic trend implies a "detaching process." Through the particular trend, the individual detaches himself, or attempts to detach himself, from what at the inception of the trend must have been a painful area of experience. In the case of neurotic trends other than detachment, however, there is an attempt to restore the equilibrium and compensate for the experiential handicaps by the use and misuse, manipulation and accentuation of real ways of influencing people. People retain their value, and it is still necessary to do things in relation to them. For the mechanism of detachment to come into being, the area of experiential injury must be so great that people are experienced as valueless, and for it to remain in existence, people must continue to be experienced as valueless. It is at great cost to the potential of the human being that this leap is made from the solid ground of human contact to the rarefied atmosphere of splendid (sometimes) but precarious (always) isolation. Once this leap is achieved, the road back entails all the difficulties of



any other neurotic trend, in addition to the specific problems involved in countering the conditioned shrinkage from meaningful contact which these patients automatically experience. Having placed themselves beyond the pale, people are willing to pay any price but one, that of psychosis. Unchecked, the end-result of detachment is psychosis, and it is the fear of "insanity" which, when real and intense enough, creates for the first time for these patients an alternative which heretofore did not exist, namely, that of getting well.

As just stated, any neurotic development includes a "detaching process" in the sense of an alteration in the appropriateness and directness of the reaction elicited by the situation. But in these individuals the detaching process is a means to an end, the end being to reach people. In neuroses where the detachment is a significant feature, the detaching process is not only the means, but—evolving out of its function, which is to delay or ward off appropriate contact—becomes the end in itself. The demands for contact are so great in the genesis of human development that almost all of the creative potential has to be invested in the establishment of a character structure which can carry the burden of endlessly maintaining the fiction of isolation. Detachment is in essence a controlled experiment in mental derangement, and so dangerous that the focus remains only upon the experiment. At some point, either the test tube breaks, or one manages to divert some attention to the experimenter. Unfortunately, by the time these situations are ferreted out, the experimenter has become little more than an automatic vehicle attempting to breathe a semblance of human aspect into the façade he has created.

Detachment, then, involves a profound alteration in the perceptive processes, resulting in the substitution for "reality as it is" of a "reality which can be ignored." It results from facing serious deprivation, and once initiated, occasions serious deprivation. Threats to the maintenance of the detachment become the only serious reality; and since the detachment is so invincible a weapon, immediate realities succumb before it and, in so doing, strengthen the defensive structure.

What happens characterologically to these people when the injury is severe enough to result in detachment is still not clear. Although applicable in a meaningful way, the concepts centering around narcissism and the failure of libidinal cathexis serve more



of a descriptive than an explanatory function, and seem too generalized for dealing with a condition which can be understood only when broken down, not only into complicated genetic factors, but also into operational techniques whereby it is maintained and propagated. Horney's evaluation of detachment, while stressing the resultant handicap and the compulsivity involved, does not sufficiently assess the unique qualities of this defensive maneuver, namely, the inexorable way in which the positive aspects of the personality are overshadowed, and the bearing this has on therapy—in short, the all-pervasive effect, the powerful, serious, and uncompromising break in the relatedness of the individual to his surroundings which is quantitatively, and eventually qualitatively, different than in the case of the other neurotic trends. The consideration given to the problem in this paper incorporates more of the serious implications of the Freudian views, namely, the earliness and severity of the causative trauma, with an outlook which is not so pessimistic as implied by Freud, nor so accessible and so manipulable as implied by Horney.

Essential to the understanding of defense by detachment, is the realization that neurotically detached patients have been subjected to environments where their treatment and recognition would have been far more appropriate had they been *objects* rather than *developing human beings*. The child encounters rigidity in the human environment to the point where his relatedness is contingent upon automatic conformity. The parental influence, appropriate for an imaginary "animate object," is totally inappropriate for the needs of the child. When the pressure for conformity is so great that the possibilities for genuine spontaneity are wholly lacking, there is an effort on the part of the child to adjust at the level of being an automaton or, in effect, a human object. Since this is impossible, he can only reach his goal by a process of simulation, based on his ability to disguise, ignore, or restrain all impulses that would be incongruous with this goal. Detachment, then, is the general term encompassing those characterologic changes designed to establish and maintain the profound degree of self-alienation necessary to make this type of adjustment.

Detached patients fall into two main, although not sharply defined, categories, depending upon the severity of the syndrome. In the first group the child is hit tangentially by the neurotic conflicts in the home. Although he may be exposed to them in the most dev-



astating fashion, his own existence is not significant to the operation of the neurotic drives of either or both parents. He is the innocent bystander who gets hurt. He is hurt, but not crushed completely. When the situation in the home approximates the conditions outlined here, the hurt results in detachment, but the injury, since it is partial, does not preclude some area of activity capable of yielding gratification. We see in these patients the severe handicap of detachment, side by side with the potentiality for growth and an almost indestructible optimism. The patient to be presented here typifies this group.

In the second group, the child not only experiences the impact of the neurotic conflicts in the home, but actually bears the brunt of the disorder. His existence forms the focal point of a destructive, neurotic fixation on the part of one or both parents. In the face of unrelenting pressure of this type, character development can take place only in defensive patterns. The total creative drive of the personality is spent in the service of maintaining the one mechanism *par excellence* capable of meeting this type of threat, namely, detachment. Any tampering with the detachment results in paranoid hostility and suspicion. Owing to the limited scope of this paper, this latter type of development—seen in psychotics and borderline psychotics—will not be illustrated by case material.

#### CASE PRESENTATION

##### *Analysis in Progress 16 Months*

The patient is a 30-year-old man who came to analysis in the midst of the following life situation:

He is an artist of a modern school whose work had achieved considerable recognition during the previous five years. About a year prior to coming to analysis, his first marriage had broken up, and the ensuing months had been characterized by feelings of despair, confusion, and frustration. Anxiety had become intense, and the patient had sought some relief through alcohol. Involved as he was, not only in painting and exhibiting, but also in writing, editing, and lecturing, he was forced, with great reluctance on his part, to participate in a round of social activities and parties which had come in the wake of his recent successes. He was beset with almost unbearable feelings of awkwardness and self-consciousness in these situations, as well as in his ordinary dealings with people. He be-



gan to feel more and more harassed and was finally incapacitated by a prolonged bout of chest infections. At the time of his first visit to the analyst, he had begun to recuperate a bit from a morass of physical and mental debility, though he still had considerable anxiety. He was concerned about his drinking and frightened lest the old feelings of confusion and panic return.

The patient's father had been an eminently successful business man. The patient recalls his childhood as characterized by a profound sense of isolation and the feeling that he simply did not belong. Both parents were concerned with possessions to the point where their protective attitudes seemed to operate more spontaneously in relation to possessions than in relation to the needs of their child. Orderliness, neatness, cleanliness, and conformity seemed to comprise exclusively all that was virtuous. The father's drive for power and prestige in the business world was matched by the mother's efforts to mold the home life in accordance with the pressures and demands of her husband's activities. She was a highly imaginative woman who in her ordinary dealings with people was flighty and ineffectual. The patient has often characterized her emotionality as primitive. The patient was an only child.

The patient was much alone during his formative years, with no close friends and very little group activity. At college he proved to be a brilliant student whose chief interest was philosophical theory. Following his graduation he studied both in this country and abroad, and finally accepted a teaching position in a leading eastern university. He held this position for a short time, and it was during this period that his interest turned to painting. In his middle twenties he left the university post and came to New York. He became acquainted with artists and soon began to paint on his own. He had had no previous experience in painting. When he did begin to paint, it was with an intensity and fervor he had never before experienced. Within a few years his work drew serious attention and at the time he came to analysis he was considered one of the leading "*avant garde*" artists in the country. He was continually in economic jeopardy despite a monthly check from his mother, which provided for his basic needs, and despite occasional sporadic financial returns from his paintings and writings.

His first marriage took place three years prior to the start of therapy. It seemed to come about with the same suddenness and intensity that had characterized his plunge into the world of art.



His wife was strikingly beautiful. She was rather distant and unresponsive, and it was only after a good deal of persuasion and initiative on the part of the patient that she agreed to marry him. She was untutored and unsophisticated, and much of the initiative that he showed in the marriage was devoted to cultivating her interest in art and literature. In many ways she seemed more naïve, impractical, and withdrawn than he. She shunned his social life and seemed actually unable to share in any social responsibilities. The relationship had a static and stagnant quality which eventually led to its termination by mutual consent. He experienced this break as both necessary and beneficial. He spoke of his wife with fondness, but also with a profound critical perception of her limitations in the marriage, as well as of his own, and of the impossibility of the relationship.

The early analytic situation was as follows: The patient had a very pleasant, agreeable approach. He was over-polite, however, almost to the point of obeisance. He would say "thank you" at the end of each analytic session. Anxiety about the therapy manifested itself by concern with the duration of treatment, efforts to manipulate the hours, and the repeatedly expressed hope that the treatment could be terminated in three to six months so that he could embark on a projected European trip. Analysis of these early features brought out his fear of involvement, his immediate reaction to a new situation as limiting and restricting, and his need to control, manipulate, and delimit any situation that was not of his own creation. He then began to focus more clearly on what heretofore had been but dimly sensed, namely, the feeling that there was something basically wrong with himself (something about himself which he characterized as inhuman) which filled him with a feeling of futility and at times desperation. He was referring to his detachment and the resultant inability to enjoy direct, relaxed contact with other people. This seemed in marked contrast to the optimism and inspiration he consistently felt in relation to his work. Despite his growing respect for the analytic process, his deferential, formal manner persisted, and there was little affective coloring to his productions except for the feeling of being trapped and helpless.

Several months after the start of the analysis, he began to broach the question of divorce. He struggled with considerable inertia evolving out of his reluctance to sever even for a brief time the



round of activities in which he was engaged in New York, to hazard a trip to Reno by himself. In addition to this, he was hampered by inflated notions of his responsibilities to his wife. He had little money of his own, and her support would devolve upon his mother. Despite these difficulties, it was felt that the move was not only right, but necessary at this time to clear the path for his own future development. He was actively encouraged, and finally did make the trip. He returned to New York two months later, having successfully carried through the arrangements with regard to the divorce. He had withstood the onslaught of his family, and he had in the interim become interested in a young woman, herself recently divorced.

During the next few weeks he spoke a great deal about this girl. Several things became apparent. She herself had just emerged from a very restricting and conventional marriage and had fallen deeply and genuinely in love with the patient. He found himself drawn to her for qualities which he had either never noticed or which were not there in the other women he had known. He was greatly taken by her warmth, her directness, and the undemanding nature of her attachment to him. There were moments when he would experience a positive sense of responsibility and commitment in relation to her, but these were, at least in the beginning, lost sight of in his fear of treading outside the sphere of art and art personalities. He feared the reaction of his friends to someone who had no special interest in art. For a time the relationship was stalemated and almost completely lost sight of.

The pressure to establish himself on more secure economic grounds—a theme which had recurred from time to time since the start of the analysis—was again considered, but this time was followed by definite action on his part. He had in the past received offers of academic posts, one of them as a professor of art, but he had rejected all of them, as he considered himself ill-suited for the quiet, and what he regarded as the restricting conventionality, of academic life. He did aspire, however, to have his own school of painting, although he had, up to this point, shied away from the idea. He greatly feared his own awkwardness and impracticality in effecting even the simplest and most ordinary business affairs. In addition to this, all the advice he received indicated that setting up his own school was the sort of venture in which only an older and more established painter could hope to succeed. On the other



hand, he did enjoy teaching and was successful at it, and he felt that he had original and significant ideas to present.

Again it was felt that the movement here was in the right direction, despite the fact that the outcome could not be certain. Analysis of the factors in his way, and encouragement and reassurance resulted in his taking the first steps. Within a few months, the school was a going concern and working out more smoothly than had been anticipated. Once this was accomplished, he seemed eager to resume and come to grips with the relationship with his girl. The two things about himself which disturbed him most—his compulsiveness about his work and his general aloofness and lack of concern for people and activities unrelated to the art world—now began to disturb him more than ever because of their specific destructive potential in relation to this girl. It was at this point that the fetishistic nature of his attachment to his own talent specifically, and to the world of art in general, was developed as a central analytic theme. His compulsive and all-engrossing concern with the art world was seen as a substitute means, although a necessary one, of relating himself to other people, a means born out of revulsion to, and intolerance of, the world as he had experienced it.

Although his talent was recognizable and real, he seemed to relate to it as if he himself were helpless, insignificant, and virtually nonexistent. He actually seemed to be trapped by the pleasure he experienced in the *act* of painting, a pleasure which seemed so all-consuming and powerful that it excluded any concern with the painting itself, that is, with the finished product. Whenever he discussed his work it was in terms of the *act* of painting; and only an occasional reference was made to a finished picture. He was impervious to the impact of his paintings on others (aloof and indifferent to his critics and his followers alike) and showed no genuine concern with an effort to harness some of the fruits of his creative energy in stabilizing his own life from the financial point of view (his economic situation having been precarious until he opened his own school). In short, he was relating in an unhuman and slavish way to his own creativity.

Once these matters were established, he began to struggle less against the recognition of his own need for the qualities which the girl had to offer. They were married within a year after his return from Reno. The marriage took place during the summer and



he was seen two months later. Despite the fact that he was still profoundly disturbed over his conflicts, the early period of his marriage had resulted in greater closeness with his wife, more real respect for her, and a greater eagerness to achieve some mastery over his own problems.

In the fall, he was again faced with the mounting pressures of preparing for exhibits, meeting editorial deadlines, arranging his school program, and participating in numerous other ventures in which he had become involved. In addition to this, there was the problem of setting up a home and studio. He became more and more aloof and distant toward his wife, lost interest in their sexual activity, which up to that point had been highly gratifying, and even at times felt reluctant to return home at the end of the day. His need to reject, withdraw, and remain uninvolved gave rise intermittantly to almost paralyzing feelings of hostility. He felt discouraged and futile in the analysis. The stage was thus set for a renewed effort on his part—although at a different level, by virtue both of his marriage and the self-confidence attendant upon his venture into teaching—to achieve his neurotic goal, namely, the pursuit of gratification in art at the expense of self-effacement and through the relinquishment of all responsibility in relation to other human beings. This attempt was again subtle and, like the initial attempt, became manifest by his efforts to control and delimit the analysis. He became preoccupied with the idea of moving to the West to free himself from the tensions and pressures which he experienced in New York, and thus be in a position to devote himself to painting in a total and more sustained way.

This material was analyzed as follows: It was pointed out to what extent his drive both toward marriage and toward analysis had incorporated within it the effort to become more human by osmosis, so to speak. Still laboring under the oppressive influence of his detachment, he had not relinquished the hope that his attachment to another human being in a passive, helpless, self-effacing sort of way could substitute for the task he faced, and conceived of as impossible—that of overthrowing his detachment and becoming a human being. Interpretations along these lines took the edge off the escapist impulses and brought out into the open his hope that what he had failed to do by himself, namely, to work out a way of life that would leave him unhampered and unfettered, he could now accomplish with his wife by severing all their ties



here and attempting a more simplified existence away from the pressures of civilization.

The fantasy of "one against the world" had evolved into "two against the world." It became apparent to what extent he was buffeted about by the importance to him of the act of painting, and to what extent this forced him to maneuver and overpower those to whom he felt closest. This understanding eased the situation in the analysis; but it was not until a short time later, that a very intuitive observation on his wife's part eased the tension at home. It occurred in the course of a conversation which took place at a time when their relationship had deteriorated to a critical level. She succeeded in pointing out to him that she did not take exception to his interest in and enjoyment of painting, but that she was puzzled by two things, first the fact that this interest seemed to be exclusively centered in the preparations and arrangements that went into the making of a picture, and not in the picture itself, and second, that it seemed to crowd out the possibilities of any other interests. It was the first time for the patient that what was most important to him was shared, accepted, and critically evaluated by a significant person. It also fanned the first genuine sparks of hope in his struggle to change himself.

The attitudes with which this patient will ultimately have to come to grips have to do with his concept of people either as dehumanized automatons, ruthlessly pursuing their predatory impulses and relating to others as if they were capable of being owned and manipulated (his perception of his father), or as basically parasitic and venting their emotionality in an aimless and uncontrollable way (his perception of his mother). His real impotence as a child in relation to this state of affairs gave rise to a negativism which, coupled with his sensitivity, resulted in a critical rejection of his own human environment and the values it represented. His existence seemed to hinge upon his ability to subjugate, not other people, as in the case of the powerful adults who surrounded him, but himself. The waste, the cruelty, and the alienation wrought upon himself and others by this attitude make a virtue of unawareness, blind him to the vulnerability of his detachment, and make an inexorable necessity of it. His talent and creativity, in forcing their way through these barriers, are cast out with little direction or goal, in hateful defiance of the oppression and melancholy that pervade his life. In rejecting the values about



him, he devotes himself to a search for absolute values. His sensitivity to line and color is a real attribute developed in his struggle to abstract beauty from the world of objects.

In summarizing the analytic process thus far, one sees that despite the fact that there has been very little analytic activity in the ordinary sense of the term, and despite the fact that the detachment is still operating, although not so effectively as it did in the beginning, the analysis has witnessed and supported some measure of real growth.

1. In the step toward marriage, the patient risked the first definite break with the kind of relatedness he had with the art world.

2. In the establishment of his school, he made the first wholehearted attempt to alter for the better the financially precarious, socially irresponsible, and generally unstabilized character of his earlier mode of existence.

3. The fact that both the analysis and his marriage have withstood his subtle but powerful efforts to manipulate and abort them has made him somewhat less fearful of his own destructive potential. It is this fear which must be mastered before he can experience his own neurosis as a reality rather than an abstraction, and can come to grips with his own terrible distorted attitudes toward people, attitudes which his detachment serves.

Although the detachment has not been fully resolved in this patient, it is no longer a bulwark against analytic progress, and some inferences may be drawn as to the factors involved in its resolution.

It is important to note that in the case of the more benign syndromes, the analysis itself actively challenges the defensive structure. In the case of the detached patient, the elements of struggle can be successfully hidden, at least in the beginning. In fact, the analysis is set up as a citadel against struggle. The analyst is not a significant figure to the patient. The latter is capable of experiencing people as significant only when they directly relate to his own area of creative function, and here their significance as people is overshadowed by their significance as manipulable and maneuverable objects. In the light of this, the steps in the process of resolution may be outlined as follows:



1. In a situation where no genuine human relationships have previously occurred, the analyst can only ally himself with a reality tool rather than a real ego. In the patient presented, this would refer to his talent and sensitivity.

2. Relatedness to people must be initiated by someone significant to the patient in relation to this reality tool. In the case of the patient presented, the neurotic component of his marriage (and by far the strongest component) was the hope of solving his human needs by blind, passive attachment to his wife. His wife thus became a significant figure to him. It is the pressure of this relationship, interpreted and handled within the therapeutic situation, which undermines his detachment and necessitates an active struggle against it. Not until the patient can actively identify himself with this struggle does the therapist become a truly significant figure for him.

#### SUMMARY

1. Genetically, detachment develops as a defense against the enforced transformation of human potential into automatic, mechanical responsiveness.

2. Resolution depends on the full understanding of the fragmentary means of contact established by these patients and the ruthlessness with which it is protected.

3. A case is presented illustrating the analytic problems encountered in the therapy of a severely detached personality.

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## THE EVALUATION OF TREATMENT\*

BY JAMES H. WALL, M. D.

In evaluating the effects of the hospital treatment of patients suffering from mental illness, many factors must be taken into consideration. In the first place, there are several different types of mental hospitals, and one would expect corresponding differences in results. There are the private and voluntary mental hospitals, the psychiatric services of general hospitals or the psychopathic hospitals, the public state hospitals which admit directly, the public state hospitals which admit from psychopathic hospitals, and the veterans' hospitals. It is hoped that studies from these various types of hospitals can eventually help to establish ways of comparing results.<sup>1</sup> As the writer's experience is limited to voluntary hospitals, this paper will be concerned with the results of treatment in the New York Hospital—Westchester Division, White Plains, N. Y.

The New York Hospital—Westchester Division, with a bed capacity of 301 patients, has spacious grounds and is well equipped for program therapies, with two gymnasias, two occupational therapy buildings, and outdoor athletic fields of various kinds. The staff is made up of 18 resident physicians, and there are approximately twice as many employees as patients. Under such conditions, the therapeutic approach is naturally intensive. In addition, preference is given to patients suffering from acute psychiatric disorders. The majority of the patients admitted are either young or middle-aged. The average age of all patients admitted is 42. Patients who do not respond to treatment over a reasonable length of time may be transferred, hence an atmosphere of hopefulness is maintained. With the ability to select patients, together with the early institution of intensive treatment, the results might be expected to be good.

Each year the hospital reports the number of admissions, including first admissions and readmissions. In the reporting of discharges, the condition of the patient at the time of discharge is recorded. This includes the number who have been on visit for a year after leaving the hospital, those who are discharged directly from the hospital, and those who are transferred to other hospitals,

\*Presented at the 107th annual meeting of the American Psychiatric Association, Cincinnati, May 9, 1951.



or who have died. In addition, at the weekly staff conferences where patients are presented for diagnostic consideration and therapeutic suggestions, the case histories of patients who were considered a year previously, are reviewed to determine their progress.

During the past 20 years there has been an increased number of admissions and discharges, because of improved methods of treatment, notably the addition of the various forms of shock treatment, which have enabled more patients to achieve a responsive state to intensive psychotherapy earlier, and the various program therapies. The hospital's statistical studies show that the number of patients under treatment during the year, as well as the number of discharges, has greatly increased. Naturally, under these circumstances, the duration of hospital residence for individual patients has been markedly shortened.

The following tabulation shows something of the activity of the hospital in 1950 as compared with 20 years ago:

	1930	1950
Number of patients admitted .....	242	329
Number of patients discharged .....	259	345
Number of patients under treatment .....	545	722
Average daily number of patients in hospital.....	251	272
Number of patients discharged who had benefited by treatment, in hospital less than six months .....	92	143
Number of patients discharged who had benefited by treatment, in hospital less than a year .....	144	244
Total number of patients discharged who had benefited by treatment .....	187	276

In addition to studying the condition of all patients at the time of discharge, the staff has made studies of results of hospital treatment of patients according to diagnostic groupings and in some instances according to occupations and professions. One of the outstanding studies made by the staff was "Results of Non-Specific Treatment of Dementia Præcox," by Cheney and Drewry.<sup>2</sup> Five hundred patients, 300 women and 200 men, admitted from 1926 to 1935 were studied. At the time of leaving the hospital, 37 per cent had been benefited by treatment and 7 per cent had recovered. The follow-up period after discharge was from two to 12 years and the results showed that 30 per cent had benefited by treatment and 12 per cent had recovered at the time of the check-



up. Approximately 60 per cent were unimproved, and 43 per cent were continuing under care in mental hospitals. The study showed that at the time of discharge 10 per cent of the patients with catatonic dementia præcox had recovered and at the time of the follow-up study, 20 per cent of the catatonic patients had recovered, showing that this group had a better chance to improve after leaving the hospital than the other types.

During the past 20 years, an increasing number of psychoneurotic patients have been admitted to the hospital. Some of these patients had been under intensive psychotherapy for a number of years before coming to treatment. They had not responded and were apparently greatly benefited by the more supportive and continued type of treatment afforded in a mental hospital. In 1941 and 1942, studies were made by Hamilton, Varney, and Wall<sup>3, 4</sup> on the results of hospital treatment of patients with psychoneurotic disorders. Of 100 psychoneurotic men patients admitted between 1927 and 1937, follow-up studies revealed that from five to 15 years after discharge, 32 were recovered. The study showed the value of a full and varied program of activities together with psychotherapy, to this group of patients.

In 1948, Hamilton and Ward<sup>5</sup> studied the results of the hospital treatment of involutional psychoses. This study was concerned with 100 women patients suffering from involutional psychoses admitted consecutively between 1930 and 1940. The results of treatment in this group which did not have electric shock therapy were compared with the results obtained in a group of 69 women patients admitted between 1942 and 1946 who, in addition to other forms of treatment, had received electric shock therapy. In the group of 100 patients who did not have electric shock therapy, after a follow-up period of from seven to 16 years, 32 were recovered; and in the group of 69 who had received electric shock therapy after a follow-up period of from one to five years, 33 were recovered. Of great importance, was the fact that for the first group the average length of hospitalization was two years, in contrast to only an eight-month period of hospitalization for the group treated by electric shock therapy. This study bore out the experience of other clinics that electric shock treatment is most helpful in shortening the period of treatment of patients with involutional mental illnesses. Oftentimes patients with involutional reactions



received several series of electric shock therapy during their hospital treatment. This therapy allays the disturbing symptoms of anxiety and agitation previously met with and greatly decreases the suicidal drives which are so prominent in this group of patients.

In 1940, Clow<sup>6</sup> reviewed the results of treatment of 100 patients suffering from psychoses with cerebral arteriosclerosis. This investigation showed that these patients had been admitted over a period of 22 years and that 11 of them were sufficiently recovered to resume work effectively, 12 were much improved, and half of them had been able to return to their homes. The study demonstrated that mental disturbances in arteriosclerotic persons are not necessarily so progressive and incurable as may be believed.

Allen and the writer reviewed the results of hospital treatment of alcoholism in 1943.<sup>7</sup> The study was concerned with 100 men who were under treatment during the period 1934 to 1940. The follow-up studies of these 100 men, three to eight years after discharge, revealed that 23 were recovered and 19 were managing better, making a total of 43 who had been definitely benefited by treatment. Thirty-three in an unimproved condition were still drinking; 15 patients had died; and for nine, information regarding their course after leaving the hospital could not be obtained. Subsequent studies of a comparable nature by other members of the staff have shown similar results.

It is obvious that these remarks are concerned with a limited experience and represent a very small proportion of the number of psychiatric patients under treatment, but they should give a general idea of what we are attempting to accomplish in our voluntary hospitals where circumstances make possible selection of patients, intensive treatment, and transfer of unresponsive patients.

Statistical studies are important, but they cannot measure some of the intangible qualities of psychiatric work and experience. Many patients who continue with a burden of illness after discharge are able to make contributions to society and are frequently a great comfort to those with whom they live. A period of treatment for a patient who is not responsive often affords time for the whole family to get a different perspective on the patient's problem. Often a mental illness is an experience through which the person moves and comes to grips with life problems in such a



way that he is able to function more effectively. The far-reaching effects of an illness in a family stimulate greater interest in psychiatry, which may lead not only to improved standards of treatment, but also to greater community participation in the promotion of mental hygiene and the prevention of mental illness.

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# A TREATMENT PLAN COMBINING GROUP AND INDIVIDUAL PSYCHOTHERAPEUTIC PROCEDURES IN A STATE MENTAL HOSPITAL\*

BY JACK GREEN, M. D.

The problem of rehabilitating state mental hospital patients by means of psychotherapy is often made exceedingly difficult by the large number of patients, the relatively small number of physicians, and the great severity of the illnesses encountered. The psychiatrist is often at a loss as to what policy he should follow. Should he concentrate his efforts on a few individuals whom he has singled out for intensive therapy, or should he try to make contact with as many patients as possible? One of the most difficult things to estimate is a patient's ability to benefit from psychotherapy. Whom should the physician choose among the scores who need his help? Should he continue treating for months and years one individual who is progressing very slowly when there are other candidates waiting who may recover more quickly, given this same attention? What is the maximum number of patients which can be treated effectively by one therapist? These questions which only remotely affect the psychiatrist in private practice, constitute an important problem which constantly faces the institutional physician. They challenge him to become more skillful in using the small amount of time he can spend with each patient. They tempt him to modify the available therapeutic techniques to fit his needs more closely. A treatment plan which has been used with some success in attempting to deal with the problems outlined here, will be described.

## TREATMENT PLAN

The plan to be presented is designed so that one physician can carry out the treatment of a group of 40 patients with a combination of group and individual psychotherapy. The therapist devotes two hours twice a week to the group therapy, and directs the rest of his time toward 20-minute private interviews with as many patients as possible. The group is constantly changing, for as certain members get better and leave, new candidates are invited to come in and take their place. Some have to remain in the group

\*State Hospital for Mental Disease, Howard, B. I.



for as long as a year or more, while others are able to leave after several months. Almost any patient who is not markedly disturbed can be accepted for treatment. Whether an individual has only recently become ill, or has had many years of treatment with the various physical therapies and psychotherapy, does not matter, except insofar as the more recent the illness, the better the prognosis.

When a patient first enters the treatment group, he is immediately invited to attend the two group therapy conferences every week. During these sessions, which will be described at some length, the physician gets the opportunity to become acquainted with the new patient. Whether the latter becomes an active member of the group or remains a passive observer does not really matter. Within a few weeks, the therapist learns a great deal about the new patient without actually taking time to interview him privately. Some individuals, of course, reveal less of themselves than do others.

Within a short time, the new member of the group becomes aware that some of his fellow-patients are receiving a lot more attention than he is from the physician—in the form of the private 20-minute interviews. Some patients are seen once a week in this way, some twice a week, and occasionally an individual has three interviews a week. These interviews are in addition to the semi-weekly group therapy conferences which everyone attends. The physician is also available to his patients at some time or other during the day for a few minutes consultation regarding pressing problems. All private interviews of longer duration, however, are regular 20-minute periods which are scheduled by the therapist in advance as part of the treatment plan for the individual patient. The patient's appointments do not change from week to week or depend on whether he feels he has any problems to bring up at the interview time. The patient can expect to continue with his schedule until he is definitely better or until there is mutual agreement that he can get along with less time.

When the new member of the group realizes that the physician spends considerable time with certain patients in an effort to help them, he begins to hope that one day he too will have private interviews. During these interviews he will have the psychiatrist all to himself and will not have to share him with others as he does during the group therapy sessions. This goal becomes something



that most patients, including many who are very sick, begin striving for to a greater or lesser degree, within a matter of a few weeks. Some will ask outright, "When can I be started on private interviews?" Others will not be so verbal, but will behave as much as possible in a manner designed to make the physician feel that he has before him a candidate who would greatly benefit from private interviews. There are also those unfortunate ones who can betray their longings only in their expressions of frustration, abandoning themselves to blind rages, breaking things, and executing other negativistic acts aimed at denying the wish to possess the therapist.

The psychiatrist must not promise anything to the patient. The latter's desire to spend more time with the physician, and the subconscious wishes which accompany this desire, originate within the patient. Eventually it will be the seeing and the acceptance of these desires by the patient which will lead toward his becoming more capable of effective and satisfying behavior. If the therapist does anything to foster even more unrealistic hopes in the patient than are already present, the latter will use this action to avoid seeing himself and will eventually, with some justification, blame the therapist for the resulting frustration. Nevertheless, the physician must still appear friendly, sympathetic and tolerant, otherwise the patient will lose all hope of any of his wishes ever being satisfied. For those patients who greatly fear their own hostile impulses, it is also necessary that the psychiatrist appear very competent and "strong." Such a competent and strong physician is reassuring to them, because, presumably, he will not permit them to express their dangerous, aggressive promptings freely, and this reassurance allows them to build a closer relationship with him than would otherwise be possible.

### *Group Psychotherapy*

The group therapy sessions at Howard (R. I.) State Hospital are conducted along the following lines. In a two-hour period much can be accomplished, even though the group is so large. The therapist does not remain passive as a rule, although there are many exceptions to this. His role is a difficult one, and no set of instructions can guide him. There are moments when he can be most effective by remaining as quiet and as permissive as possible, and there are other moments when he must push the group into



facing and accepting realities. He must bear, without retaliation, the hostility directed toward him, and yet when necessary, he must not be afraid to confront the group with material which might prove exceedingly painful. To do all this, he must have sufficient freedom from his own anxieties to examine honestly his deepest attitudes toward each patient and the group as a whole. For the first half-hour of each session, he allows the group to elaborate their own subjects. He listens carefully, trying to understand what each patient means to say and why he is saying it. After he has obtained some idea of the feelings, motivations, and resistances he has to contend with, and after he senses the mood of the group, he begins to encourage, stimulate, and ask questions. He helps develop subjects. Little by little he becomes more active in the discussion. He offers praise, criticism and inspiration. At times he allows himself to be led, at other times he leads. As he goes along, he tries to evaluate the group's reaction to what he is saying. Do they agree, are they angry, have they become anxious? Are they annoyed, irritated, or resentful? Why? Are they ready to accept what he is going to say? Toward the end of the two hours, if the discussion has progressed according to his plans, the therapist should be explaining and interpreting to a group that is anxious to listen to him.

Interpretations should be given only when the time is ripe and in a way that is acceptable to as many members of the group as possible. If the two hours are drawing to a close and the group is not ready to accept any interpretations, it is best to break off with questions left unanswered. It is important, that, if at all possible, interpretations should be given only when there are many incidents and examples at hand to help prove their correctness. During the whole two-hour period, the therapist rather bides his time, gathering and elaborating various incidents and examples brought up by the patients in order to demonstrate eventually the validity of his claims and comments. It is striking how a general statement will often mean nothing to a patient from an emotional point of view until it is associated with a specific example pertaining to that patient. If the patient has described the example himself in the presence of the group earlier in the period, the effectiveness of the interpretation is many times multiplied. The patient blushes, the group laughs. It is not necessary for anyone to confirm verbally the truth of what the therapist has said. Each patient usu-



ally sees the shortcomings of his neighbor much more readily than his own. When he hears an interpretation given which he easily recognizes as applying to his neighbor, and when he observes the latter's resistance to accepting it, even in the face of overwhelming proof, he becomes aware of a great deal which he has been sorely tempted to deny.

What are the therapist's more specific aims in the group therapy procedure? Although these vary with changing circumstances, the psychiatrist tries primarily to provide his patients with stronger and more pressing motives for seeking his help and getting better. Patients who have been attempting to satisfy their desires in fantasy are reminded constantly that ultimate true satisfaction must lie in the reality around them; that with the physician's help it is possible to achieve this satisfaction. When the members of the group are brought up against reality, they become anxious, tense and uncomfortable. They are tempted to withdraw, to run away; but they are also tempted to run to the therapist. If the latter is right there, offering his sympathy, friendship and help, those patients who are anxious and troubled may turn to him in their moment of need. This turning toward the therapist often marks the first step on the road to improvement and, perhaps, recovery. It should be pointed out, of course, that the physician must avoid provoking such overwhelming anxiety that patients are forced to retreat more deeply into their illnesses. The writer's experience has been that the more an individual has become integrated within the group, the greater has become his ability to withstand narcissistic traumata. His tendency to regress has become less marked and he has become more able to react to the therapist with anger, hostility and criticism.

Patients who need additional support during periods of emotional crisis, can at times be greatly helped by encouragement and praise given during the group therapy sessions themselves. But in addition to this, the physician must support such individuals during the private interviews he has with them. It is striking how effective he can sometimes be, even though these interviews are relatively short and far between.

The secondary aims of the therapist conducting the group therapy sessions, include focusing the attention of the patients upon the ultimate goal of getting well and leaving the hospital. There is a great tendency in state mental hospitals for patients to lose



sight of the fact that their destinies need not lie within the hospital itself; that satisfying adjustments can be made outside the hospital; that their energies can be far better directed toward improving themselves rather than toward trying to make their hospital existences more comfortable. The effectiveness of direct, verbal inspiration which the therapist can sometimes give the group, should not be minimized. He can also inspire the members indirectly by his own behavior, which he should always try to keep as sincere and as sympathetic as possible.

The existence of the group itself, offers many advantages to both the patient and the therapist. Each patient, even if he hasn't been granted private interviews, gets a chance to see his physician, speak to him, and hear him speak at least twice a week. This does away to a large extent with the feeling of being neglected which many patients develop in a state hospital. The psychiatrist would have to devote a minimum of four hours a week anyway, in trying to keep in touch with the conditions of his 40 patients even in the most superficial way. Two or more patients often have the same questions to ask and the same complaints to voice. Once these are brought up in the group therapy sessions, they can be discussed for all to hear. The group helps the new patient orient himself more quickly to his surroundings. The numerous incidents occurring between patients on the ward, their feelings and attitudes toward each other, and their day-to-day relationships with the hospital, often assume great meaning during the group therapy sessions. Patients are inspired by the improvement of fellow-members of the group. They can see how certain individuals in their midst, who are anxious, fearful, depressed, or perhaps suspicious and distrustful, gradually change in their attitudes and expressions over a period of months, and eventually become adequate enough to leave the hospital and attempt adjustment in the community outside. The physician, in meeting his 40 patients twice a week, is able to decide more readily than he might otherwise, who among the group is in the greatest need of individual psychotherapy and who would be most likely to benefit from it significantly. The group therapy sessions also provide the new patients with the opportunity of getting to know their physician at first hand and not through ward rumor and fable or through a few infrequent moments of hasty conversation. In a state mental hospital this can be very impor-



tant, for the therapist often has to serve as the first representative of reality that the psychotic patient can emotionally relate himself to with any degree of adequacy.

### *Individual Psychotherapy*

While conducting the group therapy conferences, the therapist tries to evaluate the individual members of the group with respect to their ability to benefit from private interviews. This evaluation is important, for, as has been mentioned, once the interviews are started, they should not be discontinued except by mutual agreement. Unless there is a possibility of changing therapists, lack of improvement is not cause for termination of treatment. Indeed, such lack probably indicates that the patient requires even more attention, and perhaps more enlightened therapeutic management from the psychiatrist. However, some patients require such tremendous amounts of support and time to achieve even the most minimal improvement, that it is not practicable to treat them at the expense of other individuals who can progress more readily. Trial periods of treatment are best avoided. The temptation to use them may be great, for, in this way, the physician can shield himself from therapeutic failures. Unfortunately, he will be shielding himself from therapeutic successes as well, for the patient in his repeated testing of the therapist-patient relationship often does a great deal to force the physician to give up. If the physician does give up, the patient unfortunately interprets this as a rejection or an abandonment by the psychiatrist. In such an occurrence, he finds further justification for his own way of life, for his suspicion of people around him and his flight from reality.

In the private 20-minute interviews, the patient is told that he can use the time in any way he wishes. The physician indicates that he will try to help him with whatever problems are brought up. The therapist seeks to have the patient express himself as freely as possible. He also seeks to understand the forces which inhibit such expression. Within the framework of the interviews, the patient is allowed to build a relationship with the physician which will mirror his wishes, attitudes and strivings.

The therapist's aims are best served by careful, persistent listening. Again and again he must ask himself, "What is the patient trying to say? How is he relating himself to things, events and persons around him? How did he relate himself five, 10, or 20



years ago?" In every word, expression, and gesture of the patient, there is infinite meaning, if it could but be understood. The individual uses certain modes of adjustment to deal with his internal and external pressures. What are these modes? Can they be improved? Can new ones be learned?

The physician wishes to know what conflicting forces are battling within the patient's personality. If he can uncover these forces and evaluate their strengths and weaknesses, he can organize his therapeutic efforts, whether they be large or small, to strengthen and support consistently that part of the personality which must eventually predominate, if the patient is ever to become a harmoniously functioning individual. How much of the battle raging within the patient should be revealed to him, when it should be revealed, when he should be supported, and when he should be left to work things through on his own, are complex considerations. They depend on the skill and experience of the therapist, the difficulties of the patient, the amount of time the therapist can invest in the treatment, and other factors which vary from case to case.

### *General Comments*

Although the 20-minute interviews are mainly used to help the patient make the adjustments necessary for leaving the hospital, they are also used to evaluate the individual's potentialities and future needs with respect to therapeutic management. The way is left open for a more intensive and lengthy analytic investigation and for the rebuilding of the patient's personality when and if such a procedure becomes feasible. The majority of patients are continued on short interviews after they leave the hospital. They are also invited to attend the group therapy conferences if they wish.

Our experience has been that about one-third of the patients who have been on private interviews arrange, upon leaving the hospital, to continue with one short interview a week. Another third decide to discontinue interviews, indicating that they either feel that no more are necessary or that they intend to see a psychiatrist in the community. The remaining group is a mixed one, made up of individuals who continue with as many as two or three interviews a week or as few as one or two a month. If a patient indicates that he would like to call the physician by telephone occasionally, he is encouraged to do so.



Although the plan outlined for combining group and individual psychotherapy offers certain advantages in the treatment of relatively large groups of patients, it should be noted that the effectiveness of the therapy depends on the skill and understanding of the therapist, and not on the treatment plan.

#### SUMMARY

The rehabilitation of state mental hospital patients by means of psychotherapy poses special problems, because of the large number of patients, the relatively small number of physicians, and the great severity of the illnesses involved. A treatment plan which attempts to deal with these problems by using a combination of group and individual psychotherapeutic procedures has been described. The group therapy procedures in this plan are mainly used to provide the patients with stronger and more pressing motives for seeking the therapist's help and getting better. This is done, among other ways, by provoking anxiety, offering praise and support, and by direct verbal inspiration. The individual psychotherapy procedures are mainly used to give the patient a chance to express himself, to allow him to build a strong relationship with the therapist, and to uncover the factors responsible for his illness. The effectiveness of the therapy depends on the skill and understanding of the therapist and not on the treatment plan.

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# HISTAMINE THERAPY IN PSYCHIATRIC DISORDERS\*

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## INTRODUCTION

This is a report of the use of histamine therapy in patients with various psychiatric disorders. The writers' interest was aroused by the reports of Sackler, Sackler, Sackler and Van Ophuijsen at Creedmoor (N. Y.) State Hospital.<sup>1-3</sup> These investigators have reported that this drug is safe and effective and "a therapy of choice" in the treatment of schizophrenia and other psychiatric disorders. They reported good results with the use of histamine alone and also with its use in combination with electric shock and insulin therapy. Not enough of the present writers' patients received these other therapies after having received histamine for the writers to report conclusions; consequently this report is limited to treatment with histamine alone. Also it is easier to evaluate the effect of a drug when it is used alone, rather than when it is used in combination with other therapies.

All patients in the present study had been hospitalized less than a year when histamine treatment was instituted. The technique of treatment used by the investigators mentioned was personally observed by one of the present writers (A. S. E.) and was followed as exactly as possible in the cases reported in this paper.

## METHOD OF STUDY

### *Clinical Material*

1. The writers' investigation of histamine treatments was initiated in December 1950 and terminated in March 1951.
2. Twenty-three patients at the New York State Psychiatric Institute were chosen. Twelve were female, 11 male. Chronic patients with long hospitalizations were not included.
3. The diagnoses of these patients were: schizophrenia, 16; manic-depression, depressed, 2; involutional psychosis, paranoid, 1; psychoneurosis, conversion hysteria, 2; and organic psychosis 2. The details of the specific types are included in the accompanying table. The diagnoses were made by the regular staff members according to routine practices.

\*Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, May 9, 1951.



Table 1. Patients Treated with Histamine

Diagnosis	No. patients	No. patients with previous somato-therapy	Average duration hospitalization prior to Rx	Range hospitalization prior to Rx	Average age	Age range
Schizophrenia .....	(16)	(7)	(5 mos.)	(1 to 12 mos.)	(20)	(17 to 36)
Paranoid .....	4	1	4 mos.	1 to 8 mos.	21	19 to 23
Pseudoneurotic .....	5	2	6 mos.	2 to 12 mos.	30	22 to 36
Catatonic .....	1	1	5 mos.	5 mos.	17	17
Simple .....	1	0	4 mos.	4 mos.	25	25
Hebephrenic .....	1	0	2 mos.	2 mos.	27	27
Depression .....	1	1	10 mos.	10 mos.	23	23
Mixed .....	1	1	5 mos.	5 mos.	17	17
Undetermined .....	2	1	5 mos.	1 to 9 mos.	17	17
Manic-depression						
Depressed type .....	2	1	1 mo.	1 mo.	40	35 to 46
Involutional psychosis						
Paranoid type .....	1	0	1 week	1 week	49	49
Psychoneurosis						
Conversion hysteria .....	2	0	2½ mos.	2 to 3 mos.	40	40 to 41
Organic psychosis .....	(2)	(1)	(4 mos.)	(3 to 6 mos.)	(48)	(46 to 50)
Alzheimer's disease .....	1	0	3 mos.	3 mos.	46	46
Sensory aphasia .....	1	1	6 mos.	6 mos.	50	50
Total .....	23	9	4 mos.	1 wk. to 12 mos.	28	17 to 50



4. The age distribution varied from 17 to 50. The average was 28 years.

5. Only one of the patients had had a previous mental hospital admission; this one had been in another mental hospital for a period of only four days.

6. The lengths of hospital stay prior to histamine therapy ranged from five days to 12 months. The average length of hospitalization before the institution of histamine therapy was four months.

7. Seven of the 23 patients had received either electric shock therapy, insulin coma therapy or both, and two others had received ambulatory insulin therapy prior to the histamine. All of the patients received psychotherapy prior to, during, and following, histamine.

### *Procedures*

#### PREPARATIONS

An effort was made to administer the treatment in the exact manner used at the present time by the original investigators.

All patients had complete physical and mental examinations and routine laboratory and psychological tests. The patients received the histamine in groups of about 10. They continued on their regular wards and with the usual hospital activities, and continued to see their own physicians for psychotherapy. No other medication than the histamine was given during the treatment period except occasional cathartics and sedatives. Adrenal cortical extract, epinephrine and oxygen were present in the treatment room for emergencies.

#### THE THERAPY

The histamine was always administered subcutaneously. The Creedmoor group reported in their paper<sup>1</sup> that the medication was given by the intravenous, intramuscular, or hypodermoclysis method. However, more recently the subcutaneous route was being used by them, since it is simpler and apparently equally effective. The patients' pulse and blood pressure were checked daily, before treatment. The patients were all started on 0.25 mg. of histamine base (initial injection) and given two injections daily. After the first injection, the patients' pulses and blood pressures were recorded at five-minute intervals. The initial fall in blood



pressure usually occurred within 10 to 15 minutes after the injection, and the pressure and pulse were back to normal within 30 to 45 minutes. At that time, the second subcutaneous injection of histamine was given. If the blood pressure had fallen to shock levels, or if symptoms such as chest pain and marked dyspnea occurred, the initial dose was repeated or, on rare occasions, the second dose was slightly decreased. If the blood pressure had not fallen to shock levels, the dose was increased by 0.25 mg. of histamine base for the second injection. The next day, the patient received initially the same dose as he had received for his second dose the previous day. The maximum single dosage of histamine, administered to any one patient was 5.5 mg. of histamine base.

During the treatment, the patient was asked what he felt and his observations were noted by the nurse. Also spontaneous productions were noted. A day's treatment took about one and a half hours. The patients complained of throbbing headache, flushing, itching, metallic taste in the mouth, difficulty in breathing and dizziness. However, there were no severe reactions during the treatment. On one occasion, oxygen was given a patient when she complained of difficulty in breathing. Oxygen was given to another for a marked prolonged cyanosis.

The patients received 30 treatments with three exceptions. One refused to return to the hospital after 12 treatments. One deteriorated very rapidly in behavior after 20 treatments and was put on insulin coma therapy; and treatment of one patient with an organic condition, characterized mainly by sensory aphasia, was stopped after 23 treatments for administrative reasons. The treatments were given six days a week and were consecutive except in the case of a patient who made a suicidal attempt and missed treatments for a two-week period.

#### RESULTS OF HISTAMINE THERAPY

In the first week of therapy, many of these patients subjectively experienced a feeling of greater relaxation, indicated that they were less tense and that they felt as if they were "up in the clouds," and could think more clearly. One female patient expressed the feeling, during the first treatment only, that it was as if she had had several cocktails. Whether this generally favorable effect derived from the physiological impact of the histamine or from the suggestive element associated with some form of actual physical



treatment is open to question. As the cases were carefully reviewed, it was found that most of the patients who expressed some subjective improvement during the first week of histamine treatment, had also experienced similar initial feelings of well-being when previously receiving other forms of drug therapy, such as thyroid, intravenous sodium amytal or a mild sedative. As with these other therapies, the subjective improvement was not sustained.

As the histamine treatment continued beyond the first week, almost all those patients showing initial favorable responses soon reverted to their previous states of illness, and a few complained that they were feeling worse. One male patient with conversion hysteria, manifesting hemiparesis and hypesthesia, showed a remarkable recovery after the first few injections. He did not like this treatment very well and was impatiently waiting for the therapy to end. He was a highly suggestible individual and his original symptoms began after an alleged head injury, the matter being in litigation at the time. There was some question originally as to whether the patient was not malingering. This man's recovery was in the nature of a "miracle cure." One female patient, also suffering from a milder form of conversion hysteria and constantly requesting some form of somatic therapy, showed a moderate amount of improvement. These were the only two patients who manifested any favorable response after the histamine ended.

Of the entire series of 23 patients, seven complained of being worse after therapy ended. Five were male patients and two female. This aggravation of symptoms was corroborated by objective observation. Five of these patients were diagnosed as schizophrenic, the majority of them showing some depressive symptomatology, one had Alzheimer's disease and one an agitated depression. Again it was difficult to determine whether the histamine was directly producing worsening of their conditions or whether the disease processes themselves were progressing in spite of the therapy administered. One male schizophrenic patient became so actively suicidal after the sixth histamine treatment, that therapy was discontinued for two weeks, and then resumed without in any way favorably influencing the disease. Another schizophrenic patient became so assaultive and disturbed in his behavior, with marked accentuation of his symptoms, that it was necessary to discontinue histamine therapy after the twentieth



treatment and to place him immediately on insulin coma treatment. Here it was observed that, after the seventh insulin coma, his acute symptoms subsided and he reverted to his pre-histamine condition.

### *Case Reports*

H. A., a 41-year-old man with a diagnosis of psychoneurosis, conversion hysteria, was admitted to the Psychiatric Institute on November 2, 1950. Ten days before admission he had suffered a mild head injury, associated with persistent amnesia. Neurological examination on admission revealed a hysterical right hypesthesia and hemiparesis. The patient was dependent, taciturn, depressed, anxious, and at times antagonistic. He improved slightly with previously administered psychotherapy. With histamine he relaxed more completely and his symptoms disappeared. The patient commented that he did not like the discomfort of the histamine treatment.

G. L., a 49-year-old diabetic woman with a diagnosis of involutional psychosis, paranoid type, was admitted to the Psychiatric Institute on January 22, 1951. The patient became markedly depressed, agitated and suspicious, and expressed self-condemnatory ideas following the death of her husband four months before her hospital admission. She had made three suicidal attempts during the fortnight prior to admission. With histamine, the agitation and depth of the depression diminished to a slight degree. However, she continued to be depressed, retarded, and paranoid. She subsequently responded very well to electric shock treatments.

J. M., a 17-year-old girl with a diagnosis of schizophrenia, mixed type, was admitted to the Psychiatric Institute on November 29, 1950 with severe headaches and irritability. She was seclusive, negativistic, expressed feelings of unreality, and had visual and auditory hallucinations, though rarely. Before the use of histamine, she became more relaxed and talked more freely with the help of psychotherapy. During the period of administration of histamine her irritability increased and she complained of a greater sensitivity to noise. "The histamine made me more nervous." Her hallucinations and feelings of unreality were more marked.

C. K., a 42-year-old woman with a diagnosis of psychoneurosis, conversion hysteria, was admitted to the Institute on August 10, 1950. She was a dependent, inadequate, insecure woman who had



first become depressed two years earlier following the death of her fiancé. She complained of anxiety attacks with fear of crowds and fear of riding in buses or subways. She had multiple vague somatic symptoms characterized by headaches, dizziness, excessive fatigability, and an unsteady gait. With histamine therapy she became less depressed and more interested in socializing. The somatic complaints diminished to such a degree that for the first time in years she stated she felt fine. About three weeks after the histamine therapy was terminated, discussions with her psychotherapist began to center about the possibility of her leaving the hospital and obtaining a job. All symptoms returned to an exaggerated degree.

A. H., a 46-year-old man with a diagnosis of manic-depressive psychosis, depressed type, was admitted to the Institute on December 21, 1950. Eighteen months earlier he had received 20 electric shock treatments for depression. He improved with this therapy but his symptoms recurred in a milder form five weeks later and continued to the time of his current admission despite psychotherapy. There was an additional history of brief periods of depression 30 and 14 years before, respectively. At the time of the current admission, the patient was depressed, irritable, had obsessive suicidal thoughts and vague somatic complaints. There was no change during or after histamine therapy.

#### COMMENT

The results of histamine therapy in this group of 23 patients with psychiatric disorders were exceedingly disappointing. These results are a definite contradiction of the reported improvement in 26 per cent of their cases by Sackler, Sackler, Sackler, and Van Ophuijsen. Although the total number of patients included in the writers' study was statistically limited, the group did include a sampling of the major types of psychiatric disorders.

Of the 23 patients, only two manifested favorable responses. These two patients suffered from conversion hysteria, a condition especially vulnerable to any form of suggestion. In addition to the suggestion caused by the physiologic effect of the histamine injection, the constant presence of the physician taking pulse rate and blood pressure readings every five minutes for the period of each treatment was an important psychotherapeutic factor.



Seven patients became worse during the course of histamine therapy. This aggravation of clinical findings was not attributed to the histamine effects *per se*.

The remaining 14 patients were entirely unaffected by the histamine therapy. Of this group, 11 patients were schizophrenic, two were manic-depressive, depressed type, and one case was an organic psychosis. In evaluating the effect of therapy in these cases, the temporary favorable initial response seen in many of the patients was not recorded as a beneficial response.

#### SUMMARY AND CONCLUSIONS

1. The effects of histamine therapy were clinically evaluated in 23 psychiatric patients, all of whom had been in the hospital for less than one year.

2. The diagnoses of these 23 patients included: schizophrenia, 16; manic-depressive, depressed type, 2; involutional paranoid, 1; psychoneurosis, conversion hysteria, 2; and organic psychosis, 2.

3. The results in this group of 23 patients were as follows: two patients with psychoneurosis, conversion hysteria, responded favorably. Fourteen patients showed no change. Seven patients had aggravations of symptoms when therapy was completed.

4. Histamine therapy is ineffective in the treatment of psychiatric disorders.

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## DREAM LIFE IN A CASE OF HEBEPHRENIA

BY BEN KARPMAN, M. D.

In a previous communication on the present subject,\* the writer attempted to demonstrate the structure of the psychosis and the nature of mental content in hebephrenia through the medium of two cases, James A. Q. and Dr. X. Briefly, James A. Q. was a soldier who presented a picture of a quiet, passive individual, even though he expressed in a mild way some persecutory delusions. For the most part, his mental content, dealt with bizarre, delusional material which in totality may be regarded as grandiose fantasies centering chiefly around ancestral delusions. His sex life, after a brief excursion into some activity, came to a standstill; but the mental content revealed asceticism and incest, homosexuality and effemination, and over-evaluation of masculinity. In the center of the picture, there stood incest and father fixation with paranoid projections based on homosexuality, the whole mental content being markedly a case of regression. The second case is that of a 33-year-old white, male physician who showed a number of hypochondriacal delusions in contrast to James A. Q., whose delusions were more of a grandiose and compensatory character. Parallel to James A. Q., Dr. X. showed a number of genealogical delusions and also a very meager sex life. Homosexual fantasies and a homosexual conflict were present. In this case, the Oedipus complex was definite; and, here too, as in the first case, was a positively-toned attitude toward the father. In this case too, it was around the problem of incest and the implications that stem from it that the entire psychosis appears to have been built—in order, it seems, to square instinctual pressure with the demands of a cultured conscience. But whereas in the case of Q. the attachment to the father was definite, and antagonism toward the mother growing out of jealousy was correspondingly more vehement, such father-attachment was only lightly mentioned in the case of Dr. X. and, correspondingly, the subject of the mother was merely ignored.

Both cases appeared on study to be highly symbolical representations. In particular, the study revealed some very significant, even dramatic, differences—which may be regarded as being qualitative in character—between neurosis and psychosis. These dif-

\*Hebephrenic fancies. J. N. M. D., 100:5, 480-507, November 1944.



ferences showed sex life in the schizophrenic psychosis to be strikingly different from that in neurosis. The nature and type of conscience and guilt reactions were acute and overwhelming in the schizophrenic psychotic, as compared with the neurotic. These differences also concerned the nature of the repressive mechanism in the two states; the function that delusions perform for the psychotic as against mere fantasies of the neurotic; the types of symbolization effected in the two states; and the loss of the sense of reality, a loss only partial in the neurosis but so striking and complete in the schizophrenic psychosis, with its autistic preoccupation and consequent intellectual deterioration, which is basically emotional deterioration.

While the study thus brought out a number of interesting features, one important aspect was lacking. The writer had no dream material available in the two cases. Such material is often exceedingly useful in understanding unconscious mentation. The case to be presented forthwith, also one of hebephrenia, has supplied a number of interesting dreams which, on the one hand, support the first findings and on the other hand, throw additional light on the structure of the hebephrenic psychosis and the nature of the mental content found therein.

### 1. THE STRUCTURE OF THE PSYCHOSIS

*A Delusional Theory of Evolution.* Lt. B. stood high in his class at Annapolis and for four years after graduation appeared to be getting along well but then broke down. The writer will omit, for the present, his personal history preceding the illness as not being relevant to the present discussion. So much of it as may be pertinent will be brought in later.

His genitalia, said the patient, are connected with his brain. During each "cycle," he acquires a new brain. Each time, the former brain is gotten rid of through ejaculations; and from the color and consistency of these he can tell the state of development. For instance, each time the "color becomes whiter and of finer consistency," it shows the brain is nearing perfection. When the color becomes white, then this state of perfection will have been reached. Each time after the completion of a new brain, there is a period when this "urge" is not present, and he is not aware of any genitals unless he touches them. The end result of all this will be "stronger and more potent sexual organs" and then the connection between these organs and the brain will be severed.



On formal examination his answers were relevant, coherent and fairly free, but he was not fully in touch with things. He showed considerable blocking and exhibited numerous mechanisms. He admitted having heard voices on two occasions—but merely heard his name called, each time in a different voice. He had no insight and was preoccupied with his “evolutional theory.” He was correctly oriented in all fields; remote and recent memory were defective; intelligence tests were satisfactorily performed; calculations were good; he disclaimed much knowledge of or interest in current events; general information was only fair, considering his advantages.

*Mental Telepathy.* Later the patient laughingly denied his previous delusions, but immediately gave expression to others dealing with “mental telepathy.”

He said that while he was in California he began to notice that people were reading his mind; their expressions would change rapidly, and “dirty thoughts” would then come to his mind. He appeared to be somewhat depressed, said that he was “despondent” and “miserable”; that his troubles “began six weeks ago” and that he was “helpless as a baby.” He said that he had impulses to curse everybody—his mother, God, etc.—had thoughts of fellatio and of men eating their excreta. He thought that there emanated from him a “power” that had caused unknown suffering and numerous accidents. “All accidents to everyone are the result of my having lived, of my being in the world.” He thought that because he had caused so much misery he should be taken out and burned at the stake or hanged.

*Religious Training.* In discussing his early history, little was brought out indicating early religious training and interest, although here and there an allusion to some religious statement by a relative left one with the impression that such religious matters as he heard about in childhood were mainly connected with ideas of punishment. Sometime later, however, he appears to have had at least one religious contact which exerted a considerable influence on him. The individual involved is referred to merely as “the Bible Man” (we do not know exactly who or what he was) and the patient’s account of him runs substantially as follows:

About five years ago, in the home of a widow with whom he was having an affair, he met “a very old man, aged 88 years, of short stature, who claimed to have been a professor of Bible work at Oxford and a profound student of the Bible. He claimed to have studied it especially for three years in some monastery located on the Island of Patmos, in the Mediter-



ranean Sea. . . . This man gave a course in Bible work—\$100 for 16 lessons—trying to interpret the meaning of the Bible by concentrating on a black spot, the size of a dollar. This was set up on a wall and read through the nostril—the left nostril was pressed with the finger while through the other nostril the interpretation was breathed in. This was a way to develop the right and left sides of the brain. The Bible man taught that there were 14 senses, namely, seven physical senses and seven “illuminated” senses. The physical senses became affirmation, touch, hearing, etc., all being represented by colors, green, red, yellow, blue, etc.

Of the seven physical senses, five were the usual senses, plus the sense of the blood and the sympathetic system. In the course of time the physical senses became “illuminated” senses. The brain is divided into 84 parts, each section representing some special sense—music, literature, art, etc., and each sense being represented by some particular color. The sense of smell eventually became something else; the temple of God was in the brain of the mind; he tried to connect evolution with the Bible. From the Bible he interpreted adultery as meaning sexual intercourse “with people of inferior standing, not necessarily concerning married people.” This led him (the patient) to commit adultery with a married woman. The Bible man further taught that sex life was not meant for foolishness and should not be wasted. But he did not talk much about sex, because sex was above his work. Later the patient used to meet this man now and then: “He told me once, ‘When you come to the I. M. of the law . . .’ He did not finish the sentence, and I never understood its meaning.”

### *Sex Life*

He appears to have received no sexual instruction. He says “that he knew nothing of sex matters” until about the age of 14 or 15, when, through other boys, he learned about masturbation. He also says that when he was about 12 years old he developed the fear that, when the time came, no pubic hair would grow on him, and that he was “greatly relieved when finally it did appear.” Both of these statements seem to indicate that he received no sexual information except through the usual surreptitious channels. Nevertheless he seems to have been sexually precocious, for he relates a number of childhood episodes involving sexual curiosity.

*Exhibitionism.* At the age of seven or eight, he had something like an exhibitionistic episode with a little girl. The girl reached over to play with his penis. He does not recall his reaction to this episode, but remembers that his father observed them and that he got a spanking.



*Homosexuality.* When he was eight or nine years old, he saw his brother and another boy, who had his penis out and tried to get his brother's out, too. The patient stopped this.

*Zoophilia.* When he was 10 years old, encouraged by other boys, he touched a horse's penis—barely touched it. The horse ran away. Once, out of curiosity (age not stated), he played with a dog's penis until the dog had an emission. He claims this had no effect on him.

*Voyeurism.* When he was about 12 years old, out of curiosity, he peeped through the keyhole of the bathroom door and saw the naked breast of a woman visitor. He was disappointed at the sight and never cared to peep again.

All of the incidents mentioned occurred before he was 14 and before he had learned about masturbation. The latest age mentioned is 12. In connection with these incidents, we note the repetition of the word "curiosity." Although he had apparently learned nothing about sex, he was certainly curious about it, and had already developed a number of inhibitions concerning it—he stopped the mutual exhibition of another boy and his brother; he was "disappointed" by the sight of a woman's naked breast. This "disappointment" may not have been altogether a matter of inhibition, however, but may have been determined by a preconceived phallic attraction.

Now let us continue, topically, the account of his sex life from the age of 14 or 15 when he first learned about masturbation.

*Masturbation.* After he had learned about this from other boys, he indulged in the practice on an average of about once in seven to 10 days. Following his first admission to the hospital, however, he often masturbated three times a day, and at least once every three days. Masturbation was "easier on him" than intercourse with women, but it, too, would leave him tired. The practice was accompanied by fantasies of fellatio with women, and also by fantasies of normal intercourse. He sometimes masturbated between his own legs, by pushing his penis back between his legs and then rubbing it with his legs.

It was to avoid masturbation that he would visit prostitutes. He was often obliged to masturbate at night in order to sleep. But he asserts that he got no pleasure from the practice; that on the contrary it was painful, just as intercourse with women was. It was deadening, too; it would take him a week to get over it. The whole



thing was repulsive to him, and afterward he felt low and depressed.

On October 25, 1925, he said, "Last night I masturbated to relieve the strain. It did relieve in a way, but weakened me."

In an interview on November 2, 1925, he said, "The last time I masturbated was about two weeks ago. Have not done so since then, nor have I had any nightly emission. Sex desire has left me more or less. I hardly ever think of sex now."

In a later interview he said, "I began masturbating at 15. It had a more or less deteriorating influence on me."

*Nocturnal Emissions.* During one of the early interviews he said that he used to have nocturnal emissions fairly frequently—"not so much now, last night's was the first one in a year." These were often, though not always, accompanied by sexual dreams, in which the situation would be that of lying down with a girl, kissing her or having active relations. He never dreamed of fellatio or other perverted practices. It will be seen, however, that fellatio and other perverted practices played a large part in his daily obsessive sexual thoughts.

*Homosexuality.* When B. was 13 years old, a YMCA secretary—a man about 45 years of age, married, with three children—visited his home. This man induced him to sleep in his bed and while they were together he began to fondle the patient's genitals as well as asking the patient "just to touch his." The patient refused to do the latter. The patient had an erection, but no orgasm as far as he can recall, was disgusted with the whole thing and never thought of it for years. When he was 22 years old, a friend visiting the house, tried to play with him, but the patient would not let him; the whole thing dispirited him.

When he was 14, B. had a pederastic episode with his younger brother, nine years old. He assumed the masculine role. There was no satisfaction or pleasure connected with it, certainly less than from either masturbation or intercourse. At 15 he had another similar experience with another boy, from which he derived but little or no satisfaction—did it "just out of curiosity." Since then he had no further pederastic episodes with boys.

A few months before starting therapy, he again chanced to sleep with the YMCA man, who "played with" him. The patient had an emission. It "burned." He was very disgusted afterward. See his "general attitude toward sex," in the following.



*Heterosexuality.* His first heterosexual experience was at the age of 15, and occurred because he had been told by another boy that it was the proper thing to do. Not only was he not satisfied with the experience; he was, in fact, so disappointed that he made no further attempt in this direction until he was 21. During the six intervening years, his sexual experiences consisted of occasionally petting and caressing girls—this also because he had been told that it was the proper thing to do. He would go through this procedure without any feeling; in fact, he would be quite bored by the whole business.

When he was 20 years old, he became acquainted with an aggressive young widow, who induced him to enter into intimate relations with her; but, from fear of conception, these relations were in the form of pedication, and he enjoyed them very much more than any other type of relations. Their association continued for almost a year, and during the first two or three months he would see her at least every other night.

In connection with this episode with the widow, one perceives what appears to be a considerable element of rationalization. Their relations were pedication, and he "enjoyed them very much more than any other type of relation." The reason which he gives, however—fear of conception—can hardly be accepted at its face value. It would appear rather that this reason was given to justify a procedure which was to him more gratifying than normal intercourse. One recalls his pederastic experiments with two boys (one of them his younger brother), which he claims were not satisfactory; and also a "forgotten" incident at a very early age of his father giving his mother an enema (see the following). It is strongly suspected that this pedication with the widow was to him a psychic reproduction of that earlier scene which had so fascinated him. His relations with the widow were so satisfactory that "during the first two or three months he would see her at least every other night."

Some time later, he met a young woman with whom he kept company for two years and whom he was planning to marry, "but she married someone else before I got around to her. I was pretty well broken up when she got married."

One is inclined to question the genuineness of his matrimonial intentions, although he himself probably regarded them as genuine, or the sincerity of his grief when this woman married someone else. It is altogether likely that it was his lack of aggressive interest



which caused her to look elsewhere. Part of the reason for questioning his statements in this connection will be found in his account of his relations with prostitutes; for he says that when going with a prostitute he would use a protector, for fear of disease. It was difficult for him to get an erection, the woman would have to "play with him for quite some time," sometimes for two minutes. The orgasm and ejaculation would often be so quick that some women remarked that the act was altogether too quick for them to get any satisfaction out of the relation. However, at other times reaching the orgasm would take a longer time. At no time, however, was there any pleasure connected with it. No woman ever appealed to him.

The last statement is particularly significant and, with a single possible exception, undoubtedly true—"No woman ever appealed to him." In spite of his inhibitions where homosexuality was concerned, it will be found that, when he became psychotic, the greater part of his mental preoccupation centered around homosexual practices, and that on one occasion he was discovered in an actual homosexual relationship. The single possible exception to his statement is probably represented by his mother toward whom, it will be seen, he entertained incestuous fantasies.

He describes another heterosexual relationship as follows:

"Four years ago I became acquainted with a married woman; next occasion was that we were in a company of other people at a ball game. She sat next to me, kept on pulling my arms, getting closer and closer to me—got me excited. Going back in the automobile we sat in the back seat. I was playing with her leg—she did not discourage. I had an erection but no emission. I don't recall whether I masturbated on coming home. Sometime later, I don't recall just how long, we met again in her sister's house—I took her to a hotel where we stayed together about two or three hours. I went with her several times. The erection and orgasm were all right but I was scared a lot, felt guilty. There was not much loving or caressing. Sometime later, I was with her in a closed automobile standing in front of her house. It was dark—took a chance and had intercourse with her. It was very, very satisfactory. I had her again on board a ship in my stateroom—took a chance—went with her twice. My relation with her has been responsible a lot for my condition. She had a child later on. I wondered whether it wasn't my child. She said it wasn't, and I felt greatly relieved. Yet during my sickness it came to my mind that it was my child. I was frightened and worried, and it has sat on me heavy ever since."



His reaction to this relationship was mainly one of guilt, which reaction is indeed the predominant one in his mental disturbance. We observe that he describes at least one relation with this woman as "very, very satisfactory," which would appear to contradict his statement that "no woman ever appealed to him." Presumably, a woman appealed to him under certain specific conditions which fulfilled, in one way or another, some fantasy requirement, the nature of which we do not know.

He recites still another heterosexual experience:

"In the Fall of 1924 I met a young woman. She was 26 years old, short in height, medium build, brunette. I had a kind of half-relation with her on the ground. I don't believe I got it in. I worked to get her to go with me. There was some resistance—not much love—not much satisfaction. It worried me afterward."

*Fellatio.* When he was 24 or 25 years old, he had a fellatio experience with a woman. He enjoyed this, liked it better than intercourse. However, he had no further experiences of this type with women. He thought this act was unnatural.

This was typical of his reaction to sex generally, which represented a continual struggle between impulse and inhibition.

*General Attitude Toward Sex.* He maintains that anything sexual is disgusting to him. "I hate it and get no enjoyment out of it. I feel disgusted when people talk about it." (This statement, however, was made during his psychotic period, when guilt was his predominant emotional reaction, and when his obsessive ideas were the source of continual mental conflict.)

#### PERSONALITY MAKE-UP

The general personality make-up of this patient is reflected in his interviews with the psychotherapist, partly by retrospective statements concerning his early development, and partly by psychotic expressions embodying gross exaggerations of normal personality trends. The latter are, of course, entirely disproportionate to reality, but they nevertheless furnish an index to fundamental personality traits which were a part of his make-up prior to the onset of his psychosis.

*Sensitiveness.* He has been "sensitive" ever since he can remember. If he heard people speak about him, it used to hurt. A sarcastic remark during a conversation would hurt him. It was "hard to take." He was easily disappointed; the least thing would "shake



him up so," make him feel weak for a while. It would take him a long time to get over a disappointment. The least noise would disturb him. He never got used to gunfire in the navy. He easily became seasick. "Dirty" talk offended him.

When he was 13 years old, he was in a YMCA camp washing dishes and waiting on tables; and at this time, he was wearing glasses. They called him "four-eyes," and he was very sensitive about it.

*Inferiority.* A certain amount of inferiority feeling is necessarily reflected in the preceding notes on "Sensitivity," but one gets a further expression of it in the following notes:

He is pretty sure he couldn't satisfy a woman—he has no pep, no energy. His ideal of sex life is to do without sex altogether. In many respects he is physically different from other men. True he has hair on his chest, but his penis and testicles are smaller, there is no aggressiveness about him, no guts to fight anybody, even if insulted. Was much kidded about—called sissy, girls would tease him—said they could run faster, which is right, too.

*Depression.* From as early as three or four years of age he has had moods of depression, as if something would grip him. Then the feeling would lift. While depressed, he would be fearful, apprehensive, imagining all kinds of things. The depression would be so marked that he would lose all interest in life and would not care whether he lived or not; in fact, he wanted to die. These depressions would be followed by feelings of well-being, but the depressions would last much longer than such feelings.

His abnormal depression under the influence of psychosis is apparent in many of the statements quoted under other headings in this section.

*Guilt.* The manifestations of guilt are not so apparent in what we know of the patient's normal personality, but they are present in exaggerated form in his delusional content.

"I have committed every sin but rape and murder—adultery, theft, wicked thinking, swearing, profanity, cursing God, sex thoughts about my mother, my aunt. I have no desire for rape or murder—not even in the head. I was driving in an automobile with Aunt Johnnie; thought of intercourse with her, but made no advances nor said anything.

"I feel that the influence I exercise over people kills them. It is a slow death. Train wrecks, automobile accidents, etc., all result from my thoughts, from my state of mind. That's why I tried to kill myself."

With his usual sensitivity, one would expect to find an increased sense of guilt, but under the influence of delusion this is magnified



a hundred-fold. His single adultery, his insignificant childhood thefts, his occasional swearing, his fleeting incestuous or paraphiliac thoughts, become veritable obsessions of self-condemnation. He is so sinful that his thoughts are all-powerful, causing irreparable damage to other innocent persons. All public calamities are traceable to him. He is not only guilty; he is the very personification of guilt.

*Fear.* It would seem as if fear had always been present in the patient's normal personality make-up, at least the sort of fear which is more readily associated with the term "anxiety." He says that:

"I have always been afraid of snakes and reptiles of any kind; in fact, anything resembling a snake. Even the trees here give me the impression of twisted snakes; pipe lines in the bathroom give me the same feeling.

"I was always so easily frightened and upset, more especially if it was something unexpected. If a superior officer would send for me, it would give me a nervous feeling, wondering what it might be all about; my heart went into my mouth. Before the gun-fire I would be all worked up, tense and wrought up; after the gun-fire started, it would not be so bad."

In the hospital, his fear is obsessive—a definite phobia. He refers to "this terrible fear about mental telepathy, people knowing what I am thinking about—it is driving me to destruction. I can't see how it can be true."

The fear of death is also present. "I fear hell when I die."

On another occasion, fear is extended to nearly everything. "Fear got hold of me. I am afraid to go outside. I am afraid to close the door in my face. I am afraid somebody will hit me. I am just afraid of the future. Right now I am afraid to go on the ward . . . I am just afraid to think of anybody."

Fear is sometimes one side of an ambivalent emotional picture:

"Sometimes something gets hold of me, a feeling comes over me. I don't think then of the past at all; my mind seems to be running away with me. Sometimes something grips and I feel fine; don't care what happens; seem to lose control of myself. Then again another feeling grips—I become fearful, scared to death, think of nothing but the very worst. One is the feeling of being arrogant, brutal, conscienceless, remorseless; the other is that of fear, cowardice. I seem to be cold sometimes with fear and cowardice in my heart. When I am warm, I am arrogant, seem to have no conscience, just complete brutality. Don't seem to be able to control it either. Can't understand how a man could be so destructive in his mind, such a way of reasoning. I use to think I had a sense of decency, honor, some sense of



fairness and justice. It is all leaving me now. Nothing seems to grip me except a desire to live in spite of everything."

Fear, as it is described in this passage, would seem to be a protective mechanism against aggressive impulses. The latter are undoubtedly exaggerated, like everything else in the psychotic state, and represent wish-fulfilling fantasies designed to offset inferiority feeling. Then the aggressive character of these fantasies terrifies him and he becomes "cold . . . with fear and cowardice."

*Suicide.* Suicidal ideas recur repeatedly during his second hospital admission.

"I often pray at night that somebody should please come and shoot me. . . . Before I left, Mother asked me to promise her that I will not commit suicide. I did not promise it, but her request keeps me from doing it."

A little later he says:

"I have had suicidal ideas for the last three years—more now than ever before. I don't think I have courage enough. I am a coward. Then, too, mother asked me not to do it."

Following a hospital conference at which ground parole was denied because of his suicidal expression, he said:

"Yesterday I was up before the conference for ground parole. They asked me about my feeling and I frankly said that I would like to go and throw myself in the river. They refused the parole, but I don't think I would ever make a real attempt. I no sooner think of that than my mother's request not to do anything of this kind comes to my mind, and then the whole thing falls flat."

With the increase of his obsessive thoughts, there develops an increased suicidal urge.

"The sooner I get out of the world, the better I'll be off. I thought of going to the river, but the agony of drowning is too great. Can't you please give me poison or a gun? I'll finish the thing myself. It will be a blessing to the world if I leave it—best for me and for all concerned. I am ruining my chances for future salvation. It is a terrible thing for me. You will do your duty by letting me kill myself . . . Please, doctor, get that stuff and let me die . . . I beg you, doctor, to let me have it. The sooner the better."

A day later it is the same story.

"I still entertain ideas of killing myself . . . I wish you would give me something to kill myself with. I am just a poor miserable wretch. The end is fast approaching. I don't see why I can't take the stuff before it is too late. It is no use in the world to go on. Surely you can give me something before it is too late to take me out of here—some quick-acting stuff—



can't you, doctor?—before I commit some terrible crime, cursing, turning back on mother and father. I don't even care now if it is painful. It will be less painful than the pain that is to come."

Referring to his idea of telepathy and that he is "the cause of a lot of sickness and death," etc., he says: "I don't see how to get out of it or throw it off except by suicide."

On November 21, 1925, at 6:00 a. m., he attempted suicide by hanging, having improvised a noose from the rope-like attachment to the electric fixture in his room. As he pulled the chair from under him, he fell to the floor and became unconscious. The rope broke, however, and he failed of his purpose. He soon regained consciousness, and there was a red mark on his neck. Following this attempt, he gave expression to some of the ideas of extreme inferiority and guilt which have been quoted under those headings.

### *Mental Content*

The mental content includes compulsive ideas, obsessive sexual preoccupation, paraphiliac fantasies, hallucinations, and several types of delusion. Coincident with all this, one observes a peculiar kind of insight by which the patient is "almost persuaded" that many of his ideas are absurd but which nevertheless does not free him from their tormenting influence.

*Compulsive Ideas.* When he was first taken sick, "I thought that my fate depended upon playing cribbage, whether I lost or won it." "I began to count numbers, steps on the deck, walk seven times, smoke three cigarettes—all that nonsense." "I got the idea that I had to play cribbage all night to test myself; also thought that it was necessary for me to eat fruit."

*Cursing.* The patient says that cursing used to run a great deal through his head. When someone's name would come into his head, he would feel like cursing—any one of his friends, his mother, even his father. He cannot quite explain it, as he has "nothing against" anyone.

Associating to a dream on October 26, he says:

"My mother comes to my mind. Then the sentence: 'Damn my mother—c. s.' I just can't stop these ideas going through my mind. Other thoughts flash through my mind: 'God Almighty! Jesus Christ! I am in such a disorderly state of mind. 'Mother and Father. S. O. B.'"

Later during this same session, he once exclaims, "Good God Almighty!" and once "Christ Almighty!" These profane interjec-



tions are a part of the compulsive and obsessional thought process which characterizes his psychotic state.

At a slightly later date, he says, "If I see someone, I wish to curse him . . . I don't mean these things; they are just coming up involuntarily . . . I am unsettled now, cursing the doctors and all, although knowing only too well that they are doing everything they can for me."

Several days later, he entered the room much distressed and upset. The ideas that had been constantly going through his mind were "fear of death and hell, cursing God, Mother and other people, calling the Bible horse shit," etc. These compulsive ideas torture him. He says, "I can't go on living in this agony." He then launches into exaggerated self-condemnation, and passes to some of the pleas for poison, etc., quoted under the "Suicide" heading.

The next day he says, "When I am around someone, I curse them; tell them to get away. I don't realize it . . . I curse God and then I ask His forgiveness. I curse Mother—all kinds of names."

Still later he observes, "When I was small, Aunt Johnnie used to tell me that if one curses God, lightning and storm would come along and kill him; and here I curse God in my thoughts. I don't mean to."

*Obsessive Sexual Thoughts.* All kinds of abnormal sexual things are on his mind. Wherever he sees someone, the term c. s. pops up. Some time ago he was shown a lot of obscene pictures—naked men and women in different positions, engaged in all kinds of abnormal sexual activities. He was disgusted with them, yet later, especially after he was taken ill, the memory of them would be in his mind constantly. He would imagine himself in these various positions. These fancies were mainly of fellatio with a woman, but sometimes also with a man. There were no pedication fancies. These fancies were accompanied by erection, but did not produce emission. Sometimes they were followed by masturbation.

He has sometimes entertained incestuous fancies. Preceding his second hospital admission, while he and his father were on the train, they slept together. He was then imagining rubbing closer to his father, and shuddered at the thought of it.

He can't put his thoughts into words, but mainly it is "c. s., fancies-?, etc." that run through his mind all the time. He can't help it; he can't control it.



*Coprophilia.* Coprophiliac thoughts are part of his obsessional baggage. In an early interview he said that the first time he was in the hospital a fellow patient on the ward told of a certain passage in the Bible to the effect that, before the end of time the men will eat their own feces and drink their own urine. Somehow this has often been on his mind; he used to think of it, and even thinks of it now; it just runs through his mind against his will. It produces in him a "rotten" sensation. He imagines other people and himself doing it; and sometimes it even comes to his mind when he sits at the table.

At a later date, referring to "all kinds of sexual notions and ideas of perversions," he says, among other things, that "I also think when defecating, of my mother licking the opening of my rectum. It is terrible."

*Fantasies.* In an early interview, he says:

"During my sickness I had perverse ideas about my girl friends. I imagined having a harem and performing fellatio (cunnilinctus?) on all of them; had ideas of men and animals having relations; of fish cut open, the opening being used for sexual purposes. I pictured my mother in the harem, but entertained no perverse ideas about her."

The incestuous element is close to the surface here. He included his mother in his "harem," but "entertained no perverse ideas about her." Then why was she there? Repression is only partially successful. He puts her in an incestuous situation, but denies any incestuous thoughts.

In a later interview, he says that "when fellows stand alongside of me, I think of c. s., of fellatio, of them taking my penis into their mouths. I only *think* that; it is abhorrent to me." But it will be seen that, during a later hospitalization, he and another patient were discovered in this identical situation. These "abhorrent" sexual fantasies against which he struggles are, therefore, related to a very real regressive temptation. It was during this same interview that he said, "I also think, when defecating, of my mother licking the opening of my rectum. It is terrible." (See note under "Coprophilia.") It is the torment of these obsessive fantasies which impels him to beg for poison. It is in this same interview that he says, "I am thinking these bad things about my mother and the best friend I have, yet in my thoughts I hurt her and my father more than anybody else. I am ashamed to face her or anybody in the world." It was undoubtedly this incestuous con-



flict which later, when he had made considerable improvement, was responsible for his antagonistic attitude toward his mother, when she became afraid that he would strike her with his cane. His mother is associated with his most "abhorrent" fantasy; therefore he hates her, although he loves her in her maternal role. To a lesser extent, his father is also associated with an "abhorrent" homosexual fantasy, but this is fleeting and sporadic, and one does not anywhere encounter a corresponding degree of father-antagonism. Moreover, after his second admission he was almost continuously with his mother, so that the repression of his infantile fixation where she was concerned was more often called into play.

*Hallucinations.* On October 31, 1925, he said that "yesterday for the first time here," he heard voices. "It was really just the voice of what sounded like a man, but it was not human." The voice just called his name once or twice. But a year before, at about the same time, he had heard a voice which was not the same as this one, although not unlike it in some respects. It also sounded like a man's voice, but it was light, soft and soothing—a tenor. It seemed to come from far away, yet it was near. He heard it twice, once in the morning and again in the afternoon. His Bible teacher had once told him that a voice would call him when he came to a certain point in his Bible work.

During another interview he said that, when he was "first here," he used to feel something touch or tap his knees, although he knew no one was there.

In another place, he says that, when he was first taken sick, he "heard music that did not play." He does not elaborate on this, and it is not clear what he means by the statement, but it is at least suggestive of auditory hallucinations. It was the opinion of the naval medical officers that he had auditory hallucinations at that time, although this does not appear to have been established as a fact.

*Delusions.* The patient's delusional formation varied from one hospital admission to the next. It may be divided roughly into delusions of persecution; delusions of reference; somatic delusions; and delusions concerning mental telepathy. The last did not develop until after his second admission.

*Delusions of Persecution.* In August 1924, he "got the idea that people both on ship and on shore were trying, intentionally, to get me in trouble. One night I got the idea that they were trying to



throw me overboard." Referring to this period, he says also that "one night an idea flashed through my mind that several families of girls ashore were working against me. I felt there was something in the air. Fathers of girls I had known seemed to combine to do me harm, but just what it was I couldn't say. I just had that impression. Once the idea occurred to me that there was a committee on board ship, in the admiral's cabin, to decide what was to become of me, whether I should live, be thrown overboard or what . . . thought there was a trap set for me; . . . that there were some outside influences working against me; that I was the center of some disturbance. . . . One night I got the idea that the fellows on shipboard were going to take my bunk and throw me overboard. I kept up the idea for two or three days, and then it disappeared."

Referring to the period between his first and second admissions, he says:

"I remember while in California last September I was visiting the house of a friend. Going to bed, I locked my door for fear someone might come and steal something from me; also feared that some of the women in the house might come in. Next day, remarks were made about my locking the door.

"During the last year my whole trouble was fear—fear that someone was going to harm me or do something wrong to me. Mother told me that at night I would have nightmares, yell out in my sleep that someone was after me, would cry, 'They have gotten me.' "

*Delusions of Reference.* In the beginning, delusions of reference apparently went hand in hand with the delusions of persecution. Later they took on a special character and became associated with the persistent idea of his malign influence over others, e. g., he was the cause of public calamity, destructive natural phenomena ("wrecks, cyclones, earthquakes, windstorms"), suffering and death.

In July 1924, at a movie, he thought that things he saw referred to him; thought that he was involved in affairs; that friends of his were preparing a yacht in which he would ride around the world and have a good time. Referring to this same period, he says:

"A man I knew committed suicide because the admiral bawled him out for something; he was also disappointed over a love affair, and he killed himself. I had had an affair with a married woman and this man knew it;



and I thought that he went ahead and reported me and when asked for proof he couldn't produce it."

Presumably this was *his* explanation of the suicide, which, of course, had nothing to do with him whatever.

On October 12, 1925 he said:

"I am causing lots of people to become insane, accidentally, by reason of the power that leaves me and comes back—people are changing. This power causes railroad accidents, which is awful. My presence in the world is injurious to many people—I don't understand how; it is just an observation. . . . People's voices change when talking; sometimes they appear pale and drowsy, again peppy and full of life, and it seems to me that I am the medium of all that; it seems that I exercise some involuntary control over them. I know it to be imagination, yet it seems so true to me."

The last sentence is an example of the peculiar form of insight which the patient exhibits from time to time. He knows that many of his delusional ideas must be false, but that knowledge does not prevent his entertaining them.

On October 22, he said:

"I imagine people losing their teeth; babies are dwarfed; people have nervous breakdowns, etc.—all on my account. The blight seems to affect my two brothers; they, too, it seems are having physical and nervous trouble . . . I can't see how I could be such a freak of nature as to have all these powers."

The same peculiar flash of insight is again observable. He acknowledges the improbable nature of his ideas, but the ideas persist nevertheless.

On November 22, it is stated that "he is mourning over the fact that he is a blight on this world because people know what he is thinking about, and because it affects his own people—aunt, grandmother, two brothers . . . For the last five or six days he has not read any newspaper because reading of various accidents, deaths, etc., brings to his mind that they are all due to him. He does not know how in the world it can be true, yet he believes it." Here one glimpses the same conflict—insight without insight. He is compelled to believe something, although he "does not see how in the world it can be true."

On November 5, he said, "It seems to me that everything that happens has reference to me."

On November 18, he said:

"I feel that I am the cause of my mother's last sickness, my brother's heart trouble, my father's hemorrhoids. I am afraid other people know



what I am thinking about; that I have been the cause of wrecks, cyclones, earthquakes, windstorms, people dying and suffering . . . It is awfully hard to think that I don't belong to the world; that I am the cause of misery . . . I can't see how these things can be true."

He can't see how these things can be true, but that does not mitigate his suffering, for he cannot convince himself that they are *not* true.

On October 24, he said, "I have a peculiar sensation in my throat when I see other people doing it. [*Doing what?*] It makes me feel as if it has reference to me. It is foolish, I know to think so."

*Somatic Delusions.* On October 28, the patient said:

"My body does not seem to function right now; my bowels are not right; there is something wrong with my kidney; I do not have good control of my urine. After I get through urinating a few more drops come out."

It would perhaps be difficult to say how much of this is sheer delusion and how much of it is merely delusional exaggeration. Possibly these somatic complaints had some slight basis in fact, but his reaction is in keeping with his delusional idea that practically everything is wrong—physically, mentally and morally—where he is concerned.

Reference has already been made to a statement appearing in the official case record with respect to the patient's idea about developing a new brain. Nothing is said in his interviews with the psychotherapist about "growing a tail," although on one occasion he said that at the time of his first hospitalization, "I read an article about the spine, and I thought that my spine was changing." This was perhaps coincident with the statement made in the case record to the effect that he thought he was growing a tail. On October 26, he made some statements that perhaps had some relation to this delusion as well as that about developing a new brain, and these are mixed up with certain ideas about evolution which also involve some somatic aspects. He refers to the day he was transferred to a naval hospital from shipboard, and says:

"I got to masturbating; got to thinking about fellatio; continued masturbating from once in three days to two or three times a day. Got the idea of masturbating the old brain out and masturbating the new brain in . . . I became very thin; spine was sticking out; thought the spine was growing larger. Then I began to think of evolution; tried to trace my ancestry; thought I descended from a long line of kings; that the soul of President McKinley was in me. I looked in the glass, and it seemed that my features changed; now I looked like a fish, now like a snake or other



animal. Once I thought that I had sunk in height, that I had become six inches shorter."

*Other Evolutionary Ideas.* Referring to the same period as that covered by the preceding quotation, he describes retrospectively other ideas about evolution, which appear to be independent of any somatic feature. He says:

"After I was at Mare Island for two weeks, the idea came to me about evolution. First I conceived the idea that the soul of Adam had been in people from generation to generation, and that the soul of Adam was in me . . . Then I developed the idea that there were three ages of mankind, and that there were three Adams and that with the advent of the new Adam, the old generation died away. I was the third Adam, and this generation and everything living on earth would die away and a new generation would come in its stead. About the same time, I got the idea that my grandfather and grandmother (paternal) were the third Adam and Eve. This is obviously incompatible with the other idea that I was the third Adam. At any rate, my grandparents were the third Adam and Eve, originating somewhere on earth—I don't know where and how—and that with the new species coming, the old ones were dying out. These ideas of evolution continued for six months, until about August 1925."

It is interesting to note how the patient can discuss so objectively his past delusional formation, while, at the same time, he is the pathetic victim of the succeeding one. It was immediately after the foregoing quotation that he said, "Now I have other peculiar ideas" and went on to describe the terrible things which were happening to people "all on my account." He even recognizes these ideas as "peculiar" but is nevertheless dominated by them and suffers intensely because of them.

*Delusions of Mental Telepathy.* On October 24, 1925, the patient said: "Mental telepathy keeps on running through my head. It just scares me." What follows, however, is hardly what we think of as "mental telepathy," but is rather a sort of sympathetic identification with others who are the victims of unpleasant experiences. In this connection he says:

"It passed through my mind about Dr. H., who gives syphilitic treatment here—what a hard time he has with the patients—spinal punctures. I so easily put myself into other people's positions—a man condemned to death, killed or hurt, some severe punishment, being buried alive, put in a straight jacket. I picture myself going through all these experiences; even hearing someone talk about it or just reading about it in a book. Is it my selfish disposition, inflicting things upon myself?"



On October 29, he said, "People know what is going on in my mind; they know things from my past. I exercise a hypnotic power on people, over the whole world. The attendants hate me because of that." This is mental telepathy, plus something else. He follows this up by deploring his terrible state and pleading for poison with which to end his life.

On November 10, he continues in a similar vein.

"These ideas of telepathy, and that I am the cause of a lot of sickness and death; that I am controlling life currents on earth—they are impossible, yet I believe them . . . Anything that happens I involuntarily trace to myself."

On November 6, he said that he felt like a criminal because of the terrible powers he seems to have. He couldn't understand why he should have them.

These telepathic delusions, therefore, are of multiple effect. They are all, it would seem, connected with a strong feeling of guilt. People know what is going on in his mind; and that is distressing because his mind is primarily occupied with paraphiliac fancies. He identifies himself with whatever unfortunate sufferer he thinks, hears or reads about. This is presumably a form of punishment, because his own thoughts are so bad that he believes he deserves all these misfortunes himself. Then an egoistic element enters into the situation, represented by a certain omnipotence of thought. He exercises hypnotic power, controls life currents, is the cause of sickness, death, public calamity, natural phenomena, etc. While he speaks of this only in terms of distress, there must have been certain compensatory elements in it also, for, after all, only a pretty important personage can exercise such wide influence. But he never speaks of this; for the influence which he exercises is invariably malign and is presumably the result of his evil thoughts. These horrible things for which he is responsible represent an added source of punishment for his paraphiliac fancies, and his total reaction to these delusional ideas is one of depression, fear and panic.

*Emotional Reaction.* Under date of November 2, the following comments were made on the patient's emotional reaction:

"He is still dispirited, although, perhaps, not as acutely as before, and still wears on his face the expression of despair and suffering. There is no depression as a positive portrayal of emotion such as we see in a depressed manic, but there is a very marked lowering of the emotional tone,



almost, if not entirely, to the point of extinction as far as interests in the outside world are concerned; there is, on the other hand, a complete preoccupation with inner thoughts, over which the patient shows definite emotional reaction—intense agitation over his own, to him alone, peculiar problem. It is this extreme introversion with autistic thinking as the main ideational content that is no doubt responsible for this almost complete loss of touch with environmental interests. There is, therefore, definite emotional deterioration in the patient, if by an adequate emotional reaction we mean a consistent balance between inner and outside interests, for he is absorbed in his own inner problem and is quite oblivious or rather disinterested in his immediate environment. However, what emotional reaction he does show as regards his presumed problems, which to him are acute, is quite adequate, although obviously one-sided, there is, so to say, a deterioration of interests rather than actual deterioration. This sometimes gives on casual observation, the impression of emotional deterioration, because his outward emotional reaction does not appear proportional to the degree of suffering which he undoubtedly experiences when one talks to him a bit more intimately; but that probably is due, not to any emotional deterioration *per se*, but to that part of his basic personality equipment, which does not allow as complete emotional expression as one would expect from the ideational content given. There is, we take it, fully a purity of affect and in no sense any fractioning. Such emotional reaction in itself is not abnormal, since we find many normal people whose outward emotional reaction lags behind their actual emotional state.”

Three days later, November 5, the following observation was made:

“Today the patient appeared in a slightly better condition although obviously still in quite a tensional mental state. He did not appear as uncomfortably restless as previously, rather more calm and composed. As before, however, he spoke very slowly, interrupted by rather long silences and he had to be constantly urged to continue: this, apparently, due to his absorbed mental state and the extreme preoccupation with autistic type of thinking. There is not any doubt that the man is suffering acutely and that his emotional reaction is fairly adequate, provided we grant him the premise that his imaginary troubles are real; they are real to him. There has never been any clouding of consciousness and it is only the intrusion of so many foreign ideas, enmeshed in an archaic framework on an otherwise clear background, that distorts the whole picture and gives the impression of splitting.”

## II. DREAM LIFE

Superficially, the dream life of the patient appears uninteresting, for his dreams do not of themselves reveal the intensity of his emo-



tional life. He presents a marked contrast to the average neurotic whose dreams are full of his inhibited impulses and offer a clue to his psychological conflict, but whose conscious thought reflects the prevailing cultural pattern. The conscious thought content of this patient, however, is full of regressive fancies. They are constantly going through his head. His waking hours are occupied with thoughts about all manner of sexual perversions—homosexuality, fellatio, cunnilinctus, incest, coprophilia, etc.—while at night he dreams, for the most part, of normal relationships or of situations that are completely free of sexual elements. His dreams thus become a kind of wish-fulfillment and a defense against his anti-social tendencies. This situation, generally observable in the psychotic patient, is, in the writer's opinion, exactly the reverse of that found in a neurosis. This man's dreams, therefore, are tame in comparison with his waking thoughts and his dream life is more frequently a means of escape from his obsessive thoughts rather than the season of torment so often found in the case of a neurotic whose waking thoughts are under control but whose dreams show the regressive tendencies which he is otherwise able to conceal or deny.

There is a record of 26 dreams (29 when one includes the separate dreams of a single night). The largest group represents those which contain elements suggestive of homosexual interest, although every one of these dreams is doubtful insofar as any actual homosexual content is concerned. Heterosexual dreams (of which three are emission dreams) come second. There are a few anxiety dreams; a few paraphiliac dreams; and a few dreams about his parents. The patient's associations to these dreams have already been incorporated in the notes on his life history given in the foregoing. What follows are the dreams and the writer's comments.

#### *Dreams Suggestive of Homosexual Interest*

*Dream 1.* It is the period of the Revolutionary War. He is somewhere, probably in the country, at a soldiers' camp. He is alone with a few Revolutionary soldiers around him. He promises them to get coats and food. He was unable to recognize any faces. There were no women there, nor any army officials.

COMMENT ON DREAM. The only significant point of this dream appears to be the absence of women and officers (authority). His



associations have no relation to the dream itself, but merely furnish anamnestic data. From his associations, however, it would appear that this was an emission dream, although it is not so recorded, for he says, referring to emission dreams that "last night's was the first one in a year." He also remembers that when he was first hospitalized a fellow patient told him that a certain passage from the Bible read: "Before the end of time, the men will eat their own feces and drink their own urine." This has often been on his mind, and even now he thinks of it; it runs through his mind against his will. There is here a possible connection with the Revolutionary soldiers at a camp in the country, men for whom he promises to get coats and food. The idea of their privation furnishes a certain parallel to the plight of the men "before the end of time" in the Biblical quotation. "He was unable to recognize any faces" (feces?). The manifest dream content is simple and free from any element of anxiety, but the dream thought behind it is apparently regressive; and if it was in fact an emission dream, we may be sure that the underlying dream thought was exciting. The absence of women (the choice of a setting in which women would necessarily be absent) suggests a homosexual idea, while the absence of "officials" suggests the removal of restraint or control.

*Dream 6* (October 20-21). "Dreamed I was to be sent as aide to a member of an embassy which was going to Spain. The entire dream took place in a vestibule or hallway, with four other men present. One of these men looked like Major Ketcham; one of them resembled a classmate of mine named Kincaid. He was about five feet, 10 inches high, heavy-set and stocky. Do not recall appearance of other man. The purpose of the party and the time and mode of departure were very vague. Suddenly these men appeared in a policeman's uniform similar to the uniform worn by the San Francisco police. The uniform consisted of blue single-breasted frock coat with turn-down collar as part of the coat, and straightout trousers. Do not recall the departure of these men to get their uniform. Upon their appearance I was in a dilemma as to whether or not I should obtain a uniform, and where I should go to get one. I woke up to write up the dream and then went to bed again. There was no emission."

COMMENT ON DREAM. The manifest dream content appears to be without significance. The only reason for reading any homosexual implications into it is the fact that it is concerned exclusively with men, with some physical description of one of them, and with uniforms, which are also described in some detail. There appears to



be no affect. The associations involve reminiscences of some past ambitions. Then he talks about his "guilty conscience" and relates various episodes with the married woman with whom he had had sexual relations. He attributes much of his present condition to these relations. Then he says, "I don't believe I am sexually strong enough to satisfy a wife. I have very small testicles. After having relations, I feel all tired out for a week or ten days afterward—completely worn out." This would appear to be a rationalization to justify a retreat from heterosexuality. (We know that the patient's waking thoughts are concerned with regressive tendencies; that his whole problem is one of regression; and that his sense of guilt centers about these regressive thoughts and not about his past heterosexual episodes, which only furnish an excuse for the guilt feelings.)

*Dream 7 (October 21-23).* "I dreamed I was back on the *U. S. S. Pennsylvania*. We were entering port, which one I do not recall. I was in my stateroom on the third deck when officers' call sounded. I came running up on deck, passing Major Wood (a patient at St. Elizabeths) at a place where mast was held. Running on deck I found the crew lined up for the coming to anchor. I took two puffs on a cigarette and then threw it overboard."

COMMENT ON DREAM. This dream appears to have a slight anxiety element but is otherwise without observable significance. Again there is no reason for calling it homosexual in character other than the fact that it is concerned exclusively with men. In fact the dream carries with it no particular affect.

His associations are concerned with his remembered ideas of reference which he developed on shipboard, and he tells us, among other things, that "I developed a peculiarity of pressing and pulling my nose" (masturbatory substitute?). He also thought that "the end of the cigarette would turn red, yellow, white, etc." A cigarette appears in his dream also. Probably his preoccupation with a cigarette was connected with unconscious ideas of fellatio. He recites past delusional ideas about evolution and also past Messianic delusions; then passes over to his present ideas about his responsibility for the various ills of mankind, as a result of which he has an urge toward suicide. And he concludes with a recital of ideas of practical deterioration, some of which suggest a preoccupation with regressive fancies related to coprophilia. "I am getting old; my hair is falling out; am getting physically weak. I



even smell like an old pole cat; the perspiration coming out from the pores of my skin stinks." But none of his associations have any apparent connection with the dream, which is merely reminiscent of an ordinary event in his past naval experience.

*Dream 9-B* (October 23-24). "I dreamed that I was going to an ice cream plant with a shipmate to order some ice cream. Do not remember who he was. We ordered the ice cream; do not remember for whom it was. Next I dreamed I was asleep in bed and some one pulled the cotton sheet out from under me. There was no emission."

COMMENT ON DREAM. This dream would appear to have a slight homosexual implication. We have a shipmate, ice cream, and some horseplay while the patient is in bed, which undoubtedly involved another male individual. His associations are concerned with asking his father for a nickel for ice cream and with working for an uncle in his soda-pop factory. The memory of an episode connected with this uncle, when the latter called his attention to a snake, leads to a discussion of his fear of reptiles, apropos of which he says that "pipe lines in the bathroom give me the same feeling."

Some of his statements are suggestive of unconscious preoccupation with fellatio. "If a superior officer would send for me . . . my heart went into my mouth." (A commonplace enough expression to describe nervousness, but probably with a special application in this particular case.) "I have a peculiar sensation in my throat, and when I see other people doing it, it makes me feel as if it has reference to me." (Other people doing *what?* He doesn't say.) His associations indicate a great burden of guilt. He puts himself in the place of other persons who suffer—"man condemned to death, killed" . . . "It is my selfish disposition—inflicting things upon myself."

*Dream 11* (Tuesday, October 26-27). "I dreamed that I was on the *U. S. S. Pennsylvania*. We were steaming up a river in South America, destination unknown. I was sitting in my stateroom on the third deck. An officer whom I now saw for the first time, entered my room and we started conversation. He asked me if I wanted a job when we entered port. There was also referred to in this dream the matter of some keys. I don't know in what way, but it was important. The man was of medium height, sandy hair, regular features, rather heavy set. The job he spoke of consisted of unloading gasoline and oil drums when we entered port. On going up on deck I found ourselves in another stream about 50 feet from the one we were in and facing an opposite direction. The stream was too



narrow to allow navigation of the boat; in fact, because of its large size, it occupied space beyond the confines of the stream, particularly to one side. Could not understand how we got in there and how we were going to get along."

COMMENT ON DREAM. The dream appears to be insignificant; certainly there is no reason to label it homosexual beyond the fact that the only other person in it is of the same sex as the patient. The latter portion of the dream is suggestive of a symbolized womb fantasy. The outstanding feature appears to be "some keys." A key is frequently a phallic symbol. In the patient's associations, he refers to being hit with a baseball in the pit of the stomach when he was 12 years old, and says, "I thought at that time that my testicles were knocked out." Also in his associations, he recalls that in the dream "some officers went in swimming" (nude?). "One of them remarked that he was going to retire . . . come here and build a whore house." He recalls in connection with the beginning of his mental disturbance in 1924, that "one night I got the idea that the fellows on the ship were going to take my bunk and throw me overboard" (disguised idea of homosexual assault?). He says, "I am not thinking of sex and sex perversions now as much as I used to."

Although the dream itself, therefore, contains nothing of a homosexual character, it is concerned with regressive ideas under the guise of ordinary events. This is partly indicated in the dream by the "opposite direction" in which the ship was found to be facing.

*Dream 19* (November 12). "I dreamed that I was going to the toilet in the back yard of a two-story house and upon arriving there I found myself in the midst of several hen houses. Suddenly I saw an old friend of mine sitting in the back yard of this two-story house. Eagleton and I roomed together on the *New Mexico* for two years. He invited me on a two days' fishing party, starting that night. On the way out, at a cross-roads, another car ran over my fishing tackle. Eagleton is of medium height, black hair, and heavy-set."

COMMENT ON DREAM. There are certain coprophiliac suggestions—a toilet and hen house. Again we have the physical description of a man, who invites him to go on a fishing party "starting that night." Association develops the fact that he spent a good deal of time with this man, who "used to be nervous and fidgety." Later on he says: "I am nervous and fidgety all the time," seemingly identifying himself with his former friend. He says, "The fishing



party reminds me of chicken in California—an interesting sight—heat coops. It seems like we were going fishing, riding in a car. Somehow it seemed that the fishing pole was an inch in diameter.” We recall that in the dream “another car ran over my fishing tackle” (disguised representation of homosexual assault?). This also reminds him of an actual incident in his boyhood when two other boys ran over him on bicycles (being run over appears to be similar to the picture so frequently encountered in dreams of women of being trampled by horses, etc., a disguised symbol of sexual assault).

In nearly all of these dreams, we observe that the manifest dream content is harmless and trivial and ordinary, and that there is no apparent affect (a situation altogether different from that which exists in the dreams of the neurotic, where the circumstances, even though disguised, are suggestive of strong symbolic significance and where the affect is usually great). This man exhausts most of his affect in his daily fantasies, and at night dreams of ordinary, apparently normal events in which the regressive content is so heavily disguised that it offers no disturbances.

*Dream 25* (November 16). “I dreamed that I was in Waco, Texas, and it suddenly dawned on me to return to duty. I had no orders but decided to go to San Diego which I imagined was at the mouth of the Brazos River. I went on board a hospital ship, *Relief*, which was lying at the dock. The dock was a T-shaped dock, something like the dock at Annapolis. The ship got under way and the next thing I found myself in the destroyer force office at San Diego talking to a senior lieutenant. He was of medium height, rather slenderly built, had blonde hair and ruddy complexion. I asked him for orders and he, in turn, asked me for the pay appropriation out of which my pay came. I told him it was a 5 — nm 1-k.”

COMMENT ON DREAM. There are no associations to this dream. Once more we have the physical description of a man. These repeated physical descriptions focus attention on the male anatomy and are often the only thing in the dream which suggests the possibility of any homosexual interest. We have here emphasis on “a T-shaped dock” which perhaps carries a slight phallic significance. The transition from “a hospital ship, *Relief*” to one in “the destroyer force” is suggestive of increased conflicts.

*Dream 25-B* (November 17). “I dreamed I was doing electrical work on a battleship which was somewhat similar to the *U. S. S. Texas*. I happened to pass a motor generator whose bearings were running hot. The location of this generator corresponded, in some way, to the southwest



or rather northwest corner of a house where I used to live. I took off the end plates of the motor generator. About that time a friend of mine, Mr. Eagleton, whom I roomed with a while on the *U. S. S. New Mexico*, came along. I replaced the plates in the end of the set and started up the set. No emission."

COMMENT ON DREAM. The outstanding feature of this dream for which there are no associations, is the removing and replacing of the plates on the end of a motor generator. He replaces them when a friend "with whom I roomed for a while" comes along (that is, the same friend who invited him on a fishing party in an earlier dream) and then starts up the set. This symbolization is not clear, but is at least suggestive of erotic significance. The only other person in the dream is a male friend. The generator "corresponded in some way to the southwest or rather northwest corner of a house where I used to live." The bearings of the generator "were running hot." There is apparently a childhood association involved which is not clear. Electrical apparatus is frequently associated with sex in dreams, as are ideas of electrical influence in delusions. We are vaguely justified in calling this a homosexual dream, although there is nothing sexual at all about its manifest content.

### *Heterosexual Dreams*

*Dream 2* (October 15-16). "I dreamed that I was to be married. The affair was arranged by my father—it seems that he insisted on me getting married, not that I particularly wanted. I did not know who the girl was until after the ceremony. She was more of a brunette, dark-complexioned young woman about 23 to 24 years of age, brown hair and eyes, average height, a little heavy set. After the ceremony my father, myself and the girl were to go east. They boarded the train, but somehow I missed it, but managed somehow, by getting on at another station to catch up with them. I don't know how I did it. We were all the time on the train, but I stayed away from my wife for a period of time—a day or two—and then went to her sleeper. She had a bathing suit on. I started having relations with her, but barely started when I woke up, having a nocturnal emission. It was probably about 4 to 5 o'clock in the morning."

COMMENT ON DREAM. There were no associations to this dream. While it is a heterosexual dream insofar as its manifest content is concerned, it exhibits a great deal of material suggestive of homosexual conflict. His father arranges the marriage; the patient does not even know who his wife is until after the ceremony; he misses the train; and when he does catch up with it, remains away



from his wife for a couple of days. His wife is wearing a bathing suit. Everything is calculated to impede and delay the ultimate heterosexual relation, which seems to take place from a sense of duty rather than because of desire. He has a premature ejaculation in the dream just as he invariably did in waking life whenever he attempted relations with prostitutes.

*Dream 3* (October 16-17). "I find myself in an apartment of a girl whom I have known before. I cannot say how I got into the apartment, nor can I recall who the girl was—but she was someone I knew before. The apartment seemed to be a nice place. She was a young woman, blonde, slender in build, medium height. We just talked—can't recall what we talked about. Not through her telling me, but in some way, I got the impression that she became a prostitute. We did nothing in a sexual way, not even kissing or caressing. Then I went to see the other girl. She was tall, slender and brunette. Her apartment was a number where last digit was 5. I just talked to the girl and then left. Nothing transpired between us. Either after that or sometime between these periods I went down town. I did not immediately wake up from this dream, but shortly after that. There was no issue nor do I recall any emotional reaction to the dream. The whole dream is very vague and many details are lacking."

COMMENT ON DREAM. Here, there is a heterosexual setting, but this is certainly not a sexual dream. Associating to the dream, the patient complains of the "peculiar ideas about sex abnormalities" which keep running through his head. He recalls red light districts in Panama; then talks about a widow with whom he went for one year, after which she married someone else; also about another woman with whom he went for two years, when she also got married. He was "pretty well broken up" when she got married. He says: "This is really what started my trouble." He also mentions some money difficulties in the navy in connection with his mother's allotment, involving strict regulations. (These circumstances are not clear.) The principal emphasis in the dream appears to be on the fact that the girls became prostitutes. Guilt and sex are intimately associated. The girls represent sex; he has nothing to do with them, but he thinks of them only in terms of prostitutes.

*Dream 4.* (October 18-19). "I find myself in bed with a girl, both having our clothes on. She was of slender build, medium height and blonde. Using my hand, I played with her organs until she had an orgasm. She, too, played with my organs without, however, obtaining an orgasm from me; then I awoke. There was no emission."



COMMENT ON DREAM. In this dream there is a sexual relation, but it is inhibited and confined to preliminaries. He and the girl both have their clothes on. Their activity is confined to masturbation. He doesn't have an orgasm, even in the dream. His associations include a recital of the ideas already mentioned in the account of his hospitalization—that he is responsible for railroad accidents, is causing people to become insane, that his presence in the world is injurious to others, etc., etc. He has some insight into the delusional nature of these ideas, but is nevertheless unable to control them. The Oedipus factor is clearly indicated by his statement "It splits my own family . . . I feel that I am a detriment to both sides. It breaks my poor mother, and that is what hurts me most." (His thoughts do injustice to his mother.) Now he recalls what appears to have been a traumatic episode.

"When I was about four or five years old, I saw my father giving an enema to my mother. It seemed to me that she had a penis like a man. That's why for a long time I did not know that there was any difference between man and woman. I forgot about this incident until the day of my sickness."

Here certainly is the idea of the "phallic mother" which may have an important bearing on his homosexual development. He continues:

"During my sickness I had perverse ideas about my girl friends. I imagined having a harem and performing fellatio [cunnilinctus?] on all of them. Had ideas of men and animals having relations; of fish cut open, the opening being used for sexual purposes. I pictured my mother in the harem, but entertained no perverse ideas about her. When I was at home, my room was separated from Mother's by a curtain. I feared that people might suspect us of having relations. During my last sickness, when my mind was awlirl, I did have ideas of having relations with my mother. I might have been poisoned by someone—don't know by whom. I had peculiar ideas about my birth; sometimes I feel I am not the son of my father."

The quoted passages show very clearly the accumulated burden of Oedipal guilt which the patient carried, with all of its bizarre ramifications. One also observes the remarkable contrast between the comparatively innocent character of his dreams and the perverse sexual content of his tormenting thoughts when he is awake.

*Dream 14.* "I am in a room and there is a girl stenographer writing on a typewriter. She was of medium height, rather tall for a girl, blonde hair, slender, rather pale. I don't know what I was doing, but I believe I was doing some kind of executive work, but can't recall the nature of the work.



There was somebody else in the room—I don't know who he was or what he was doing. I believe he was typewriting. Following this dream I had an emission, which woke me up; it was a pleasant dream."

COMMENT ON DREAM. The manifest dream content has no sexual element; nevertheless B. had an emission. "There was somebody else in the room. I don't know who *he* was or what *he* was doing." (*Italics the writer's.*) This appears to be the key to the dream, which is really homosexual rather than heterosexual in character. Who *he* was and what *he* was doing are forgotten. He says, "I don't remember what relations we had to bring about the wet dream." (A tacit admission that he did have some kind of relations with some one.) He recalls early ambitions, and remembers the room he had when he spent part of the preceding summer with his father. "I don't think there is any companionship that I enjoyed more than that of my father and mother." (Was his real reaction to their separation one of guilt because of the Oedipus situation?)

*Dream 17* (November 10). "I had some dream about Mrs. F., the charge nurse on the ward. It was something about the routine in the ward. It was not anything about sex, and there was no emission."

COMMENT ON DREAM. He recalls that he once grabbed his charge-nurse by the arm. "I was just feeling good and didn't mean anything by it. Later I took a dislike to her." (Guilt reaction.) He continues talking about his "ideas of telepathy" and says, "They are impossible, yet I believe them."

*Dream 21* (November 14). "I dreamed that I went into a movie in company with a girl who lives in Summerfield, Alabama. This girl is short, rather heavy-set, blonde and has a round face. This building was somewhat like the auditorium of Hitchcock Hall. We went into the balcony of the movie, about six rows from the front. This row had a very high back—about five feet I should say, and a narrow seat about eight inches. About the time we were seated a fight started in the Negro section, which was in the back of the balcony. No one seemed to interfere with the fight. There was no emission, although there was an erection."

COMMENT ON DREAM. Again the manifest dream content is without any sexual element. Sex is undoubtedly represented by the fight in the Negro section with which "no one seemed to interfere." Although he had no emission as a result of this dream, he did have an erection. Associating, he recalls going swimming with a Negro boy. "I ducked him and nearly drowned." Thus the homosexual element appears again. It is the memory of swimming with a



Negro boy that excites him—not being with a girl at the movies. He remembers that a man living next door to him once fired a shot at some Negroes (the fight in the Negro section). Shooting is also suggestive of sexual assault. When he ducked the colored boy, was he sexually excited? He also says: "I remember 1915—walking along the street—middle-aged man—yellow [woman?]-scared and left him." (Why "scared? Was there some suggestion of a homosexual advance?")

*Dream 22* (November 15-16). "I dreamed I was in a house of prostitution. Remember four women in four different rooms. I witnessed an intercourse between a man and a woman in one room. The man was of medium height and weight and had very black hair, which was combed pompadour style. Do not remember anything at all about the woman. As a result of witnessing this intercourse, I had an emission."

COMMENT ON DREAM. He witnessed intercourse between a man and a woman and had an emission. Concerning this, he says: "It seemed that the man was so placed on the woman that his whole body from the lower ribs up projected over the woman's head." Then it couldn't have been normal intercourse. The woman must have been performing fellatio on the man.

*Dream 26* (November 18). "I dreamed I was standing on top of a three-story building in a city which seemed to be Dallas, Texas. Suddenly an animal or a figure resembling in shape that of a bat, but heavily set, with very heavy trunk and wings, came flying down the street about on a level with the top of the building and alighted on the ground about three blocks further. As soon as it alighted it changed into a woman of medium height, rather slender, black hair and somewhat sharp and defiant features.

"The bat-like animal was brown in color; the body was that of a coarse creature. It didn't have wings or feathers, but heavy, scaly arms at the side. It seemed that the skin was that of a crocodile. The woman was not human, a peculiar creature of some sort, maybe a cross between a human and an ape. I remember her saying something about men, but I forget now what she did say; it was something derogatory. She said it to a crowd that gathered after she alighted. I was present in the crowd, although I don't know how I got there. She alighted about three-four blocks from where I was. She had a dress on, a skirt that came up to the hips and blue in color, and a shirtwaist on, which I believe was red; and a black felt hat; she had stockings and shoes on, but don't remember looking below her knees. Her face looked like that of a girl I knew several years ago. Woke up thinking I had an emission, but there was none."

COMMENT ON DREAM. He thought he had an emission but there was none. The dress clearly embodies his fear of sex. The woman



is an inhuman creature, part bat, part crocodile, but her face reminded him of a girl whom he had known. He recalls being on top of a building looking at the city; and also a girl who went to the top of a building to look at a fire which was in his father's house. (Fire is passion. The woman reappears in the dream as a frightful creature because the memory of her is associated with thoughts of sex.) The girl whom he is reminded of by the dream woman is one with whom he used to go driving. "She was a good and fast driver, and when driving with her my heart jumped." (Relation of motion to sex.) He continues with the idea that he is responsible for other people's sickness, including "my father's hemorrhoids." He also recalls an airplane ride during which he had an intense desire to urinate—"bladder bursted, or nearly bursted." (Relation of motion to sex; substitution of urine for semen.)

### *Anxiety Dream*

*Dream 12-B* (October 27-28). "I dreamed of three figures—three corpses standing up. One was five feet, six inches tall, the other five feet, nine inches, the third, five feet, 12 (six feet) in height. They all had the same face. They were the same person in different attitudes. The figures had hollow-drawn places on their cheeks around the mouth; they were all pale cadaver looking. I woke up from this dream with a start, frightened. There was no issue. This was just a snatch of a dream."

COMMENT ON DREAM. This is an anxiety dream. Presumably the three corpses are multiplications of himself. His associations have almost no relation to the dream itself, but reflect his continual state of mental suffering and a great deal of his delusional content which is largely a projection of his guilt feelings onto his environment. The dream is one of the few with affect: He woke up startled and frightened.

*Dream 13.* "I am all alone and deserted and I came to a terrible end, cursing God, thinking I am crucified, burned, going to destruction, then was left alone in the open."

COMMENT ON DREAM. An anxiety dream which embodies the idea of punishment for his sinful (paraphiliae) thoughts. It is mainly a reflection of his waking delusions, which it continues, on this occasion, even in sleep.

*Dream 20* (November 13). "I dreamed that I was getting ready to take an examination in steam engineering at the naval academy. I was somewhat nervous about it because I was not prepared for it. My seat in the classroom was in the second row from the left and the seventh seat from



the front end of the row. Do not remember the instructor's name or his description. The examination questions were mimeographed on paper and each student received a separate set of questions. One of the questions was: "What pumps are used to empty a ship which has sprung a leak, or been in collision?" "

COMMENT ON DREAM. He says "the ship which has sprung a leak or been in collision." His nervousness in the dream is a repetition of his actual feeling whenever he took an examination. Examination suggests self-examination, which is intolerable, because of his repressed paraphiliac and criminal impulses. Referring to examinations at the naval academy, he says "If I did not know a question, I would use my imagination to finish it." Apropos of "imagination," he remembers that "I would often imagine that I was to be hanged." (Punishment for repressed impulses.)

### III. SUBSEQUENT DEVELOPMENT

The following data from the official case record continue the account of the patient's career in and out of the hospital up to the time of his death.

At a conference to consider ground parole, he stated that he wanted to go to the river and jump in. Parole was denied.

On August 13, 1926, he and another patient were discovered in homosexual relation (fellatio), he being the passive partner. At this time he denied hallucinations or delusions, but admitted having had them. He was described as being cross and irritable with his mother when she visited him; and she said that on one occasion she feared that he was going to strike her with his cane. He was also reported as giving voice to obscene expressions and approaching women with sexual suggestions, for which reason it was necessary to prevent his attendance at Red Cross entertainments, etc.

Throughout the succeeding months his condition fluctuated, at times showing improvement and then exhibiting a relapse. On March 8, 1927, he became excited and assaultive, and this condition continued for the balance of the month. On January 19, 1928 he was granted ground parole and handled this privilege well. On October 1, 1928 he was granted indefinite visit to his mother, who had moved to Washington and was living near the hospital. On February 27, 1929, he was discharged as a social recovery.



*Third Admission*

On June 3, 1929, he was admitted for the third time, coming from the local naval hospital where he had gone at the suggestion of his personal physician. He was quiet and agreeable. It was stated that he had become very restless while waiting to hear the results of a civil service examination; that he would walk the floor, wring his hands, and laugh foolishly. He could give no definite reason why he should be returned to the hospital, but accepted the situation agreeably and said that he was willing to remain under treatment as long as desired, but hoped that it would be only a short time.

During the second month following this admission, he became noisy and disturbed. Attendants reported that he masturbated frequently and shamelessly.

On October 31, 1929 he was reported as having improved considerably; and in December he was again given ground parole, which he handled well until January 1930, when it had to be taken up because of his noisy behavior. He continued to show variable emotions, conducting himself well on the grounds during the day, when he had a special attendant, but being noisy and troublesome at night. On May 31, 1930 he was reported as having been much worse for several weeks; but by October he had again improved sufficiently to have his ground parole restored, and was able to work in the laboratory, where he was very industrious and efficient.

On November 8 he was again permitted to go on indefinite visit to the home of his mother. He was seen at frequent intervals by social service workers during the spring and early summer of 1931, and continued to improve.

On August 21, 1931, he returned to the hospital upon the advice of his relatives, who said that he was somewhat upset and possibly hallucinated. He was well behaved and admitted a history of hallucinations but said that he could not describe them, that they were confused and jumbled.

On January 14, 1932 he was reported as falling to the floor in response to the dictation of "voices" which told him to do this. In February he would not admit hearing voices or having enemies. By December 3, 1932 he was again quiet, and said that he could not remember what he had been excited about or exactly what he had done. Ward notes in March stated that he was reacting to auditory hallucinations. On May 20, 1933 he had a period of acute



excitement during which he yelled, was resistive and unmanageable. Later he said that he had yelled because he was having a baby and declared that he had had eight or nine children during the night.

On May 22, 1933, he was taken ill and died the following morning of chronic valvular heart disease. Permission for an autopsy was refused. The mental diagnosis was dementia præcox.

#### IV. DISCUSSION

This is one of numerous cases in which early psychiatric attention might have gone far toward delaying, if not averting catastrophe. The patient's father records symptoms at the age of 16 which were clearly indicative of abnormal development and consonant with a typical dementia præcox reaction.

The hereditary picture is not at all clear. Nothing is known about the "insane" cousin mentioned in the medical certificate. A maternal uncle died of heart disease, which was the cause of the patient's own death. Another (paternal?) uncle "took to dope and drinking" after the tragic death of his young daughter. The patient's next younger brother also has heart trouble, is nervous, and "always had difficulty holding a job."

The parents did not get along well together. The patient had been told that they "were almost divorced" at the time of his birth, and that "terrible things happened—some scandal." When he was seven years old, they actually were divorced and he has said that he "remembers vividly one scene which took place" just before they separated, but he would not tell what it was.

A broken home situation thus influenced his childhood development. Apparently there was a fairly strong attachment to both parents, for he says that "it always hurt him that he couldn't be with both of them." He made no comment on either one with respect to their differences and never voiced any criticism of either of them. It is perhaps significant, however, that in connection with his compulsive ideas of cursing other people, it was more often his mother whom he felt impelled to curse than his father (although he did occasionally curse his father, too). During one part of his second admission he showed great irritability toward his mother when she visited him, and she once became afraid that he was going to strike her. It would thus seem that she was the subject of a greater share of unexpressed criticism and resentment



than his father. But she was also the source of his major conflict where incestuous ideas were involved; and part of his periodic antagonism to her was undoubtedly the expression of a defense reaction against these ideas. Once, during his illness, he admitted entertaining death wishes against her:

"I frequently thought of inheriting mother's property—what I would do if I had it. Felt guilty for planning on Mother's death."

That incestuous temptation was at the base of his psychogenic difficulties, it is impossible to deny, for these temptations were not represented by an involved symbolization, such as are found in so many schizophrenic cases, but were consciously present during the patient's disturbed periods. He told the writer that when he was at home his room was separated from his mother's by a curtain and that he "feared that people might suspect us of having relations"; and admits that "during my last sickness, when my mind was awlirl, I did have ideas of having relations with my mother." (See the comment on Dream No. 4.)

B.'s bi-polar parental attitude is further indicated by the fact that once he entertained incestuous thoughts toward his father. And it is known that, when he was 14, he once did have incestuous homosexual relations with his younger brother. The writer has already commented on the unusually pleasurable character of his pedication with the aggressive widow and has suggested its possible connection with the strong (and strongly repressed) impression made upon him at a very early age when he saw his father give his mother an enema. His early asocial tendencies were typical of many homosexuals and there seemed to be no doubt that his true psychic trend was in a homosexual direction, although all the homosexual advances which were made to him met with full or partial resistance because of his inhibitions. One finds mention of only one satisfactory experience with what was presumably normal coitus, and one is led to suspect that, even there, some unknown paraphiliac element, either actual or fantasied, entered into the situation. His preferred form of heterosexual gratification was passive fellatio, but here again inhibition generally prevented both active and passive fellatio with men, although on one occasion he was discovered as the passive partner in fellatio with another patient.

The controlling factor in his psychotic exhibition was the overwhelming sense of guilt which was expressed for the most part in



his delusions concerning what he himself referred to as "telepathy" but which, as already shown, were mainly concerned with his responsibility for all the terrible things which were taking place in the world, as though God were punishing all mankind for *his* sins. This was a sort of Messianic delusion in reverse. Instead of being God incarnate, he was the equivalent of an incarnate devil, spreading plague, pestilence and famine, sin, sickness and death, the only difference being that, rather than glorying in the exercise of such diabolical influence, the patient regarded it as a curse and insisted that he should expiate it with his life. To a considerable extent, these delusional ideas represented an unconscious expression of the patient's sado-masochism, for they appeared to satisfy at one and the same time a strong aggressive tendency and a thirst for suffering. Some of his paraphiliac obsessions served the same purpose. He called an associate "dirty f. c. s." and visualized his mother licking his anus when he defecated. These obsessions were the essence of sadism. In contrast to these he imagined himself eating excreta, pleaded to be hanged, burned at the stake, etc., and even attempted suicide as a means of self-punishment for his sinful thoughts, as well as in an attempt to escape the suffering which these thoughts caused him.

As one reviews his recovery and subsequent relapses, we appear to be concerned with the alternating control and failure of repression. There is no index to his thought content after the conclusion of the interviews which furnished most of the information embodied in this survey, but his subsequent admissions were attended by hallucinatory disturbances and increasingly bizarre behavior indicative of a deteriorating tendency. His final delusional episode, involving ideas of childbirth, may have been largely somatic in character and loosely connected with the cardiac disturbance which, only a day or so thereafter, caused his death.

In an attempt to understand the psychodynamics behind the patient's reactions, it may be observed that for all his sexual precocity and his multiple excursions into different types of paraphiliac behavior, these activities were essentially weak, timid and ineffective—a little of this and a little of that but no more—attaching himself to nothing definite, thus differing strikingly from neurotic and criminal paraphiliacs who elect particular, preferred forms of paraphilias, with energetic excursions into other paraphilias, adjutants and expedients. He was not unlike a little mouse, moved by



the tempting smell of cheese to touch it, just a lick; then terrified, running back for fear of getting caught. The patient's ramifying mental content—in particular his delusions and hallucinations—preoccupied as it was with all sorts of paraphiliac behavior, was in effect in the nature of strong defense reactions erected by a too robust and over-severe conscience, to prevent him from realizing the variety of paraphiliac drives. Lt. B.'s psychosis thus reveals itself as only a protective barrier that prevented the over-flooding of the personality with socially prohibited sexual behavior. And if it be true that reaction is at least equal to action, then the very malignancy of the psychosis was but an indication of the tremendous strength of the original impulses behind it. The psychosis killed the man; but society was spared the sexual criminal he might have become, had the barriers not been strong enough and had his impulses broken through under the pressure of instinctive drives.

This case is but one of many in which the ambition to succeed has resulted in intellectual development in an individual constitutionally and psychogenically incapable of standing up under the strain imposed by the normal social life of a prevailing culture. B. was able to pass the entrance examinations to the naval academy and to graduate therefrom with a high scholastic standing, but was obviously unfitted constitutionally and temperamentally to make a corresponding social adaptation, with the result that after a few years of active service, he became a total loss. Knowing what we do of his early life, it is obvious that this fact should have been discovered by others long before that naval career was opened to him. Psychiatry which only begins after a personality disintegration has put an individual inside the walls of a mental hospital is of little social value. Cases like this represent a crying need for an earlier and more constructive type of psychotherapy designed to prevent such costly mistakes.

#### V. COMPARISON OF LT. B., JAMES A. Q., and DR. X.

##### *The Role of Physical Factors*

There were no physical difficulties in Lt. B.'s history on which he could blame his condition, whereas James A. Q. and Dr. X.\* both blamed their breakdowns on army experiences—the first on having been gassed and on a severe fall, while the second blamed

\*Ibid.: J. N. M. D., 100:5, 480, November 1944.



his condition on the "shell shock" suffered as the result of an explosion. The actual naval career of Lt. B. is not known, but there is nothing to indicate that he ever participated in battle or had any wartime experience to which he could attach any of his subsequent difficulties.

### *Homosexual Indications*

In all three cases, one finds strong indications of homosexual pressure. In Lt. B.'s case, there is an actual homosexual history. At the age of 14, he practised active pederasty on his nine-year-old brother, and a year later had a similar experience with another boy. Concerning the first, he said, that "there was no satisfaction or pleasure connected with it," and concerning the second, he claimed that he did it just out of curiosity. There were several instances of sexual familiarity with other men, in which they were the aggressors, only one of which culminated in orgasm, with respect to which he says that "it burned" and that he was very disgusted afterwards. His only protracted heterosexual relationship was confined to active pedication, which he says he practised because of his fear of conception, but which actually appears to have involved a compromise formation derived from his homosexual inclinations.

With another woman, B. enjoyed passive fellatio, but his sense of guilt would not allow him to repeat this experience because he thought it was unnatural. At the time of his breakdown, the naval authorities did not attempt a definite diagnosis beyond establishing the conclusion that he was psychotic, but included as part of their opinion the label, "homosexual panic," which indicates that his reactions at that time clearly showed a strong preoccupation with homosexual ideas. During his second admission to St. Elizabeths, he was once discovered in a homosexual relationship with another patient, he being the passive partner in fellatio. The largest classified group of dreams represents those which contain elements suggestive of homosexual interest, although they are without actual homosexual content. (The majority of his dreams are, in fact, without sexual content of any sort, but his associations invariably led to an expression of the regressive fancies with which he was so persistently tormented.)

In the case of James A. Q., there is no homosexual history that the writer is aware of, and all indications lead one to conclude that



there was none. The patient's entire delusional structure, however, appears to be predicated on a strong father fixation. Positively-toned sexual attitudes toward his father are suggested by his sleeping with him most of the time as a boy, loving to feel his muscles, undue curiosity about his father's visits to his mother's bed, and strong unconscious reactions of jealousy connected with these visits. There is a suspicion of considerable voyeuristic activity where his father was concerned, although we have no actual admission of this. His father fixation is reflected in his ancestral delusions, e. g., that he "came from a king snake" (symbolization of paternal strength). His paranoiac delusions of jealousy on the part of others were derived from his homosexual attachment to his father, with its resulting homosexual inclination generally—which took the form of paranoid projection. His grandiose delusions were also traceable to father-identification, which involved the well-known "overestimation of the sexual object"; he "felt he had been led by divine power"; that he "was just as important as Jesus Christ," etc. His periods of "slipping" following which he developed feelings of shame and remorse (but the actual psychic content of which is unknown to us) were undoubtedly associated with regressive fancies connected with his homosexual father-attachment. He complained of the advances of "two homosexual patients," and it was not known whether this represented a fact or a paranoid projection of his own unconscious homosexual interest. The core of his psychosis represents a conflict over his incestuous interest in his father.

The same situation is apparent in the case of Dr. X., except that in his case one suspects the incestuous interest of extending to several members of his family, of both sexes; for the purport of his elaborate delusional system was obviously to make them other than his kin. As pertaining to the homosexual picture, there is the undue significance which the patient attached to his highly developed mammary glands (the over-development of these glands was a physical fact), suggesting ideas of effeminization; his positively-toned emotional reaction toward his father; one of his delusional statements that "they would not ordinarily put a female nucleus into a male body"; his indifferent reaction to his mother's death (which occurred during his hospitalization); his violent reaction to a question regarding homosexual practices: "It is very rare, it is immoral, abortionist, bastardy and cannibalism"; and



his specific denial of his blood relationship to his father and three of his brothers by investing all of them with "invented bodies" (a device created to enable him to surmount the incest barrier). Unfortunately in this case, there is no information with respect to the patient's emotional or sexual relations with any of the members of his family. One is merely left to suspect the existence of numerous episodes within the family circle which involved sexual stimulation, perhaps voyeuristic and/or exhibitionistic incidents, although probably none which were concerned with overt sexual behavior. He was the youngest of nine children, and it may be supposed that the family life afforded considerable opportunity for the development of sexual impressions within the home circle.

### *Delusional Structure*

The main point of departure in delusional structure where James A. Q. and Dr. X. were concerned was its (passive) compensatory or grandiose character. Delusion saved both of them from the unutterable misery which afflicted Lt. B. James A. Q. was "led by divine power" and by being "just as important as Jesus Christ." He also developed fantastic delusions of evolution and descent—he "came from a king snake" and there were "gorillas in between." Even his paranoid delusions do not appear to have caused him any appreciable amount of suffering, for they involved the compensatory thought that they resulted from his superiority, of which others were jealous. Dr. X. had an elaborate and intricate delusional pattern which made him and the other members of his family the creation of the "Watts," who had invested them with "invented bodies" which presumably made them a generally superior set of folks. In both of these cases the grandiose delusions disguised the incestuous factor which, in the case of Lt. B., could only find expression through tormenting thoughts of a frankly recognized paraphiliac character that only increased his feeling of guilt and unworthiness.

The delusional content of the three cases shows considerable variation. Lt. B. was so continually occupied with obsessive paraphiliac fancies that delusion played a comparatively small part in his mental disturbance. Most of it occurred in connection with his initial breakdown and was consistently paranoid, its content resembling superficially that exhibited by James A. Q. He thought there was a combination against him, "fathers of girls spreading



stories" (a paranoid projection of guilt feelings). There were also many ideas of reference; he connected incidents in movies with himself; thought that people knew what he was thinking about, etc. (fear of discovery of his paraphiliac thoughts). His somatic delusions had a little in common with those of Dr. X. He thought he was growing a tail, and concluded that this was a manifestation of "brain evolution," which idea was employed to justify his masturbatory practice, the end sought being an ultimate severance between his brain and his sexual organs (castration complex?). On his second admission, his delusional content was concerned exclusively with ideas of "mental telepathy"—people were reading his mind; their expressions would change rapidly, and he would then have "dirty thoughts." During his last admission he was periodically hallucinated and indulged in bizarre behavior at the dictates of voices. His last delusional episode was somatic in character and was perhaps connected with actual physical disturbance resulting from his developing heart disease. He thought he was giving birth to a baby and said that he had had eight or nine children during the night. This was only two days preceding his sudden death.

In the cases of James A. Q. and Dr. X., there were ancestral delusions designed to disguise incestuous desires. With James A. Q. these were not so clearly stated and by no means so systematized as with Dr. X. They were more or less zoological, being concerned with man's relation to the animal kingdom. The patient "came from a king snake" and there were "gorillas in between," the first idea being associated with the paternal phallus and the second with his childhood impression of his father's unusual strength. There were also compensatory delusions of grandeur connected with his exaggerated idea of his father and his father-identification; he "felt he had been led by divine power" and that he was "just as important as Jesus Christ."

Dr. X. also had some grandiose delusions involving a great number of inventions of a mechanical nature, and also some in the field of medicine. At the time of his hospitalization, however, he had completely discarded these and recognized their absurdity, realizing that he had never invented anything in his life and that all the "inventions" he had mentioned in letters to his sister had actually been in use for many years. But the ancestral delusions persisted and were so complex as to defy comprehensive description. They



involved a mythical race of people called "the Watts," who "have to do with emotional relationship" and who were responsible for the "invented bodies" of himself and the other members of his family, the reason for this idea of "invented bodies" apparently being one which enabled the patient to indulge with impunity in fantasies of incestuous relations which were thus rendered not incestuous because the persons involved were, according to this delusional theory, not members of the patient's family at all. The name "Watt" was identified, even by the patient himself, with the well-known unit of electrical energy, thus connecting electricity with sex in a manner commonly observed in any number of psychotic cases. This elaborate genealogical theory apparently served to save the patient from all guilt reaction, and therefore one finds in his case no paranoid delusions. He was not the victim of any sort of persecution. The "Watts" had so completely taken care of everything that he had no guilt feelings to project upon his environment.

#### *Hallucinations*

Hallucination played a negligible role in the case of Lt. B. until his last hospitalization, when it was more in evidence. He fell to the floor at the dictates of "voices" and also experienced imaginary birth pains. Dr. X. was obviously hallucinated, reacting with the silly laughter of the typical hebephrenic. James A. Q. expressed the idea that he had been hallucinated in the past "up until two or three years ago," but there is no mention of hallucinatory episodes during his hospitalization, although it was suspected that his admitted practice of "talking to himself" might be a hallucinatory reaction, as well as his statement that he "feels that he has two minds, an evil mind and a good mind" and that he "has no control over the evil mind," it being suspected that "the evil mind" referred to, represented hallucinatory suggestion.

#### *Psychogenesis*

From a psychogenic standpoint, nothing is known of Dr. X. whatever. Such childhood episodes or impressions as may have influenced his development are completely outside our knowledge. The writer has already speculated that because of the "invented body" delusion which removes him from kinship with most of his family there were probably incidents in his life as a child which had an incestuous coloring, but we actually know nothing about these.



In the case of James A. Q., one knows a little more. As a child, he slept with his father, loved to feel his father's muscles, and would pretend to be asleep when his father visited his mother's bed, thereby concealing his interest in and curiosity about these visits. One suspects that similar pretended slumber covered a variety of voyeuristic incidents where his father was concerned, but there is no actual admission of this. His initial jealousy of the intimacy between his parents was later reinforced when his mother's infidelities became known to the neighborhood and other children taunted him with the information that his mother was a "bad woman." The roots of a definite father-fixation are thus shown in his case.

With respect to Lt. B., there is more information than in either of the other two cases. At an early age he saw his father giving his mother an enema, and it seemed to him that she had a penis like a man. There was a traumatic conflict incident to his parents' separation and a vivid memory of a scene which took place between them shortly before this event, the nature of which he would never discuss. During adolescence his development was characterized by many symptoms which boded ill for the future—withdrawal from group activities, periods of absorption when he would stare into space, etc. He was extremely sensitive and highly imaginative; and he reacted with hurt and withdrawal to being branded by his associates as a "sissy." He never developed any spontaneous interest in the opposite sex. There were two known homosexual episodes at the age of 14, and several abortive ones at a later age.

Lt. B.'s only protracted heterosexual relationship was with a woman on whom he practiced pedication. He developed an acute sense of guilt concerning everything related to sex, and his idea of an ideal state was one of complete asceticism. Whatever organic factors may have entered into the development of his psychosis, there was, in his case, a clear picture of continual, psychogenic sexual conflict, and it was this picture which clearly characterized all of his psychotic periods. Frankly incestuous episodes filled his consciousness during the height of his psychosis, and there was probably no form of paraphiliac activity which did not at one time or another torment his imagination. His sense of guilt was constantly active; and his delusions were projections of guilt feelings; whereas Dr. X., by reason of his delusional evasions, appeared to possess no sense of guilt whatever; and the guilt feelings



of James A. Q. were associated with recurring periods of "slipping" which were followed by feelings of shame and remorse. In James A. Q.'s case, delusions appear to have saved him in part from a sense of guilt arising from his incestuous father-fixation.

The psychogenic common denominator in all three cases is the unconscious fear of incest, but its manifestations represent considerable variation. In the case of Lt. B., one finds almost continuous and unrelieved suffering. The patient is obsessed and tormented by paraphiliac fancies which increase his feeling of unworthiness and bring him to the verge of suicide. Even his delusions offer no amelioration of his unhappy state but rather tend to aggravate it. He is the cause of all human disaster and all public calamity. All his waking thoughts are a compulsive preoccupation with filthy ideas, for which he continually reviles himself and on account of which he suffers extreme torment. Only in his dreams is he free of them, for the dreams depict, for the most part, innocuous situations which contain almost no trace of sex; but once he commences to associate, he is sooner or later swept back into the paraphiliac whirlpool of sexual obsession.

#### *Degree of Insight*

The amount of insight exhibited by these three patients is perhaps about equal. Lt. B. clearly recognized his deplorable state; in fact, he seemed inclined to exaggerate it; but he had no realization of the fundamental situation which produced it. Nevertheless he improved during each of his first two hospitalizations to the point where he was capable of making some sort of social adjustment, and even attempts at economic adjustments, although the latter, in both instances, appeared to be more than he was equal to and to have been precipitating factors in new attacks. How his third hospitalization would have terminated had it not been for his heart disease, which put a sudden end to his earthly career, one does not know; but there were indications that at that time a certain deterioration had begun to take place, and the outlook was not good.

James A. Q. developed only a limited insight into his difficulties, at which time he appeared to approach, somewhat, the wavering uncertainty of neurosis; but usually there lay behind this a more or less fixed nucleus of delusion which concealed and rendered inaccessible the roots of his mental disturbance. He was discharged for transfer to a Veterans Hospital and track of him was lost.



Dr. X., after two years in the hospital, was discharged to the custody of his sister, and his subsequent history is not known. He developed insight to the extent that he was able to recognize and discard his original grandiose delusions concerning inventions; but this type of delusion was immediately succeeded by a second, involving his complex ideas of genealogy, the control of mankind by the "Watts," their investiture with "invented bodies," etc., which type of delusion apparently remained fixed. Perhaps he really exhibited the least amount of insight of the three patients, for he continued to show a definite splitting which enabled him to talk of himself and his family in a factual manner at one moment, and immediately thereafter discuss them in the light of his delusional system, which made them the "invented bodies" of the "Watts." He also exhibited many of the reactions characteristic of hebephrenia—vacant starings into space, silly laughter as if in response to hallucinations, misidentifications, and other evidences of splitting. But of the three patients, he definitely appears to have suffered the least, for his complex delusional system so completely disguised his sexual preoccupation that the latter did not disturb him, whereas it disturbed James A. Q. periodically and made life a more or less continual hell for Lt. B.

#### SUMMARY

The case of Lt. B. is one of hebephrenia and provides an opportunity for comparison with two previously studied cases of James A. Q. and Dr. X., for in addition to furnishing material dealing with unconscious mental content, the patient also furnished a number of significant dreams which make possible an even better understanding of the structure of the hebephrenic psychosis.

#### *Hospitalization*

The young Lt. B. had stood high in his graduating class at Annapolis and was apparently satisfactorily performing his naval duties when, four years after graduation, he broke down and required hospitalization. By the time he reached the hospital he was found to be preoccupied with a delusional evolutionary theory in which he postulated a connection between the genitalia and the brain, the latter becoming purer as the seminal fluid became whiter. This theory had its origin in the teachings of "the Bible man" who showed him how to "interpret the Bible through one nostril!" He also interpreted adultery to mean sexual relations with people of an inferior stratum of life.



*Sex Life*

Of his sex life it was learned that although he had no formal sex education and was rather ignorant in many ways, he seems to have been sexually rather precocious, which, as is known, is not unusual in psychoses. When he was seven, he indulged in exhibitionistic games with a little girl and was spanked by his father for this. At eight, he refused to participate in homosexual activities with his brother, but two years later he attempted sex play with a horse and a dog, finding it, however, most uninteresting. At 12 he was disappointed at the sight of a nude woman's breast he spied through the keyhole.

At 12 he developed the fear that when the time came no pubic hair would grow on him, and was greatly relieved when it finally did appear.

At 13, B. was seduced by a YMCA secretary, aged 45, and was disgusted by it. At 14 or 15, he learned masturbation and practised it about once a week, accompanied by fellatio fantasies involving women, occasionally fantasizing heterosexual intercourse. Later, to escape masturbation which he felt was repulsive, he resorted to prostitutes with little success or satisfaction. At 14 he had a pederastic experience with his younger brother and at 15 with another boy, both giving him no pleasure or satisfaction. At 15 he had his first heterosexual experience but was so disappointed that he abstained for six years and when he again had intercourse, it was with a widow with whom he had—as a precautionary measure—only pedication, which was also more enjoyable than normal relations. A few months before his hospital admission, he again performed a homosexual act with a man and had an emission. Normal intercourse was marred by premature ejaculation, and he confessed that he received much more gratification from fellatio but desisted because he felt it was “unnatural.” Nocturnal emissions occurred only when he dreamed of heterosexual intercourse—not of perversions.

*Mental Content*

During his hospitalization he was completely preoccupied by obsessive thoughts of homosexuality, paraphiliac fantasies, hallucinations and delusions, incestuous fantasies involving his mother, and all forms of sexual activity in general which were overshadowed by a tremendous and deeply torturing sense of guilt. The delu-



sions were of four types, persecutory, reference, somatic and what he called "mental telepathy." They were really self-condemnatory, making him feel responsible for all the major and minor catastrophies which befell the world. He found himself compulsively cursing everyone, even his parents, and his thoughts were filled with obscene words and pictures. He was obsessed with coprophiliac ideas stemming from a Biblical reference to men eating their own feces. He had incestuous desires toward both parents, and this made him extremely antagonistic toward his mother. He even fantasied her licking his anus during defecation.

### *Dream Life*

In contrast to these nightmarish waking hours, his dream life consisted of ordinary, apparently normal events in which the regressive content was so heavily disguised that it offered no disturbance. A total of 26 dreams was available, most of which were homosexual (heavily disguised) and a few heterosexual, anxiety, paraphiliac and parent dreams. With very few exceptions, the dreams were entirely free of overt sexual situations and were wish-fulfillment in character, serving as a defense against his anti-social tendencies. During the recital of his dreams, several "forgotten episodes" came to light, the most significant of which was a scene of early childhood when he evidently had witnessed his father administering an enema to his mother and thought at the time she had a penis (the phallic mother). This was probably the basis for his great enjoyment of pedication with the widow.

### *Guilt*

It further became apparent that guilt was his real reaction to the separation of his parents because of his fixation on both mother and father. His insistence that the marriage of his girlfriend to another man was responsible for his "nervous breakdown" merely served to emphasize the real cause—his heterosexual maladjustment, his homosexuality and his incestuous cravings. This feeling of guilt was not evident in his normal personality make-up but became exaggerated in his psychotic state. This manifested itself in his second set of delusions—that he was responsible for all public calamities and all natural disasters. His normal feelings of sensitivity and inferiority were also extremely exaggerated, as was his fear, which appeared more like what would usually be termed



anxiety. This fear was his protection against his aggressive impulses.

His strong attachment to mother and father and the great guilt thus carried, resulted in his Messianic delusions in reverse—God was punishing all mankind for *his*, the patient's, sins. These delusions were an unconscious expression of his sense of guilt. His entire hospital course was an alternation of control and failure of repressions. And as the latter process took over, deterioration set in; and his final childbirth delusion appeared to have some connection with the cardiac disturbances which caused his death.

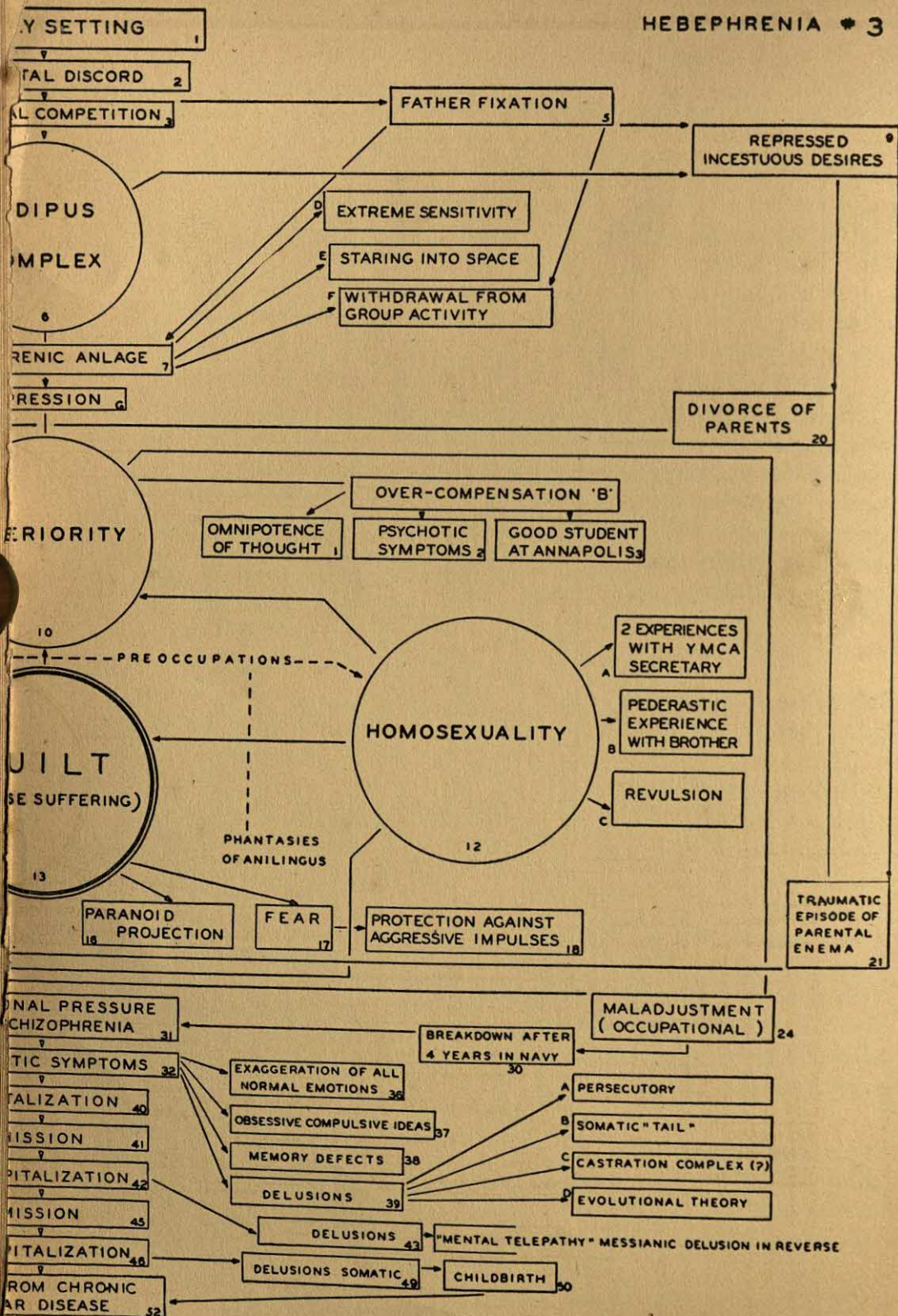
In terms of the psychodynamics involved, the patient's behavior, though precocious and seemingly diversified, was essentially very weak, passive rather than active, and totally ineffective. He had hidden his impulses and interests in paraphilias behind a thick cloak of obsessive preoccupation with them. The psychosis, it appears, was erected against indulgence in socially-prohibited sexual behavior, thus serving a useful social function, albeit in the end killing the patient.

### *Course of Illness*

Since the age of three, B. had frequent periods of depression and was often preoccupied with suicidal ideas, no doubt related to his guilt feelings. However, his promise to his mother prevented him from attempting suicide until his second hospitalization when he tried unsuccessfully to hang himself. During the second hospitalization, the patient was denied ground parole because he still admitted his suicidal ideas, and sometime later he was discovered in the role of the passive partner in fellatio with another patient. Two and a half years later he was finally discharged as a social recovery but four months later was admitted for the third time in a highly disturbed condition, hallucinating actively and masturbating constantly. He had a rather stormy course for four years with only brief periods of remission. He finally asserted one day that he was having a baby and two days later died suddenly from chronic valvular heart disease.

In retrospect, one observes that his schizophrenic behavior was noted by his father when the patient was only 16, so that early therapeutic endeavors might have forestalled the development of his malignant hebephrenic psychosis and prevented his tragic death.







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*Comparison of the Cases*

In comparing Lt. B. with James A. Q. and Dr. X., it is clear that all three felt homosexual pressure—James A. Q. suffered from a father-fixation, Dr. X. extended his incestuous desires to several members of his family irrespective of sex, while Lt. B. was attached to both parents. The grandiose delusions exhibited by James A. Q. and Dr. X. saved them from the miserable existence of Lt. B. Hallucinations were prominent in Dr. X.; no mention was made of them in the case of James A. Q., although he was observed frequently to be talking to himself, while Lt. B. admitted auditory hallucinations only during his second hospitalization.

The insight shown by all three men was approximately equal, and the psychogenic common denominator in all three cases was the unconscious fear of incest; but its manifestations represented considerable variation. The psychogenesis of hebephrenia was best demonstrated in the case of Lt. B., because he was able to give the most information, especially as concerned his dream life.

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## PSYCHOANALYTIC CHART—CASE OF HEBEPHRENIA (LT. B.)

The diagram illustrates the case of a young navy lieutenant, Annapolis graduate (3), who was hospitalized at St. Elizabeths Hospital (40) because of a breakdown after four satisfactory years in the navy (30). He blamed his breakdown (31) on the marriage of his girlfriend (29), although he later admitted that he never "got around to marrying her" himself.

In the hospital, he displayed psychotic symptoms (32) such as sexual preoccupation (33), depression and despondency (34), self-condemnation (35), exaggeration of all normal emotions (36), such as fear, inferiority, guilt, etc., obsessive-compulsive ideas (37), memory defects (38), and delusions (39). The delusions were of four kinds: persecutory (39A); somatic (39B), the idea that he was growing a tail, and that there was a connection between his genitalia and his brain; delusions reflecting the castration complex (39C); and an evolutionary theory (39D), the theory of several generations of Adam.

During Lt. B.'s hospitalization he produced a considerable amount of anamnestic material, including 26 dreams. From this material, a fairly extensive psychogenetic picture of his life could be reconstructed.



The family setting (1) was characterized by parental discord (2); in fact the parents almost separated at the time of his birth, but the patient would not reveal the nature of their disagreement. There was, apparently, competition (3) between the parents for the affection of their children, and out of the Oedipus situation (6) there developed mother-identification (4) and father-fixation (5).

Because of his mother-identification (4), the patient developed many effeminate traits and was branded a sissy by his friends (7A); he had a vivid imagination (7B) and later developed an ambivalent attitude toward his mother (7C). Although he never expressed hostility against his father, he frequently cursed his mother during his illness.

Out of his father-fixation (5), there appeared his extreme sensitivity (7D), his staring into space (7E), and his withdrawal from group activity (7F). During B.'s adolescence, the father was aware of the boy's peculiar behavior and therefore, the schizophrenic *anlage* (7) was already present at that time. As early as the age of three, the boy suffered from periods of depression (7G) which continued to his death.

As long as he could remember, he had had incestuous desires toward both parents (8, 9), which were repressed until the onset of his acute illness. The Oedipus conflict thus produced a great sense of inferiority (10), both physical and mental; and he over-compensated in two directions (10A, 10B).

He developed sado-masochistic traits (10A1), which later became apparent in his delusions. He became selfish (10A2) and egotistic (10A3), characteristics which also manifested themselves in his delusions. On the other hand, he began to feel superior by believing in his omnipotence of thought (10B1), by developing his psychotic symptoms (10B2), and by choosing to go to Annapolis (10B3) where he made excellent grades.

In the most traumatic of all events, when he was seven, his parents were divorced (20), and for this he blamed himself.

His whole sexual life was distorted by his Oedipus conflict (6), and he masturbated (12) with guilt (11) and revulsion (12A). To escape masturbation, he turned to prostitutes, which resulted in more guilt (11) and revulsion (14).

Homosexuality (13) appeared early in his life, as demonstrated by pederastic experiences with his brother (13B) and with the



YMCA secretary (13A). Both cases produced marked revulsion (13C) and further guilt (11).

Guilt (11) dominated his whole life, and produced intense suffering which was greatly exaggerated during his psychosis. It produced fear (17), which also acted as a protection against his aggressive impulses (18). It made him project (15) onto his environment, and made him feel responsible for major public calamities (15), so well illustrated in his Messianic delusions in reverse (43A).

And behind this was the long-forgotten traumatic scene of his childhood, when he accidentally saw his father giving his mother an enema (21) and thought that his mother had a penis.

The patient repressed his heterosexuality (22), which resulted in his severe heterosexual maladjustment (23). When he did not masturbate he had nocturnal emissions (25). His heterosexual contacts were unsatisfactory because of premature ejaculation (26) and guilt feelings (14). He confessed that the only satisfactory relationships with women were either pedication or fellatio (27), but he stopped these because he felt they were unnatural. No woman appealed strongly to him (28) with the exception of his mother, who appeared in many of his masturbatory fantasies.

The one girl who appeared somewhat attractive to him married someone else (29), and although he asserted this precipitated his breakdown, his actions belied this.

His occupational maladjustment (24) took place after four successful years in the navy (30), and he was finally hospitalized (40). His promise to his mother not to commit suicide (19) prevented him from attempting it until his second hospitalization (42).

At that time, his delusions had changed character and were strictly "mental telepathy" (43A), although actually they consisted of his claim that he was responsible for all public calamities (15) and were Messianic delusions in reverse (43A). It was then that he tried to hang himself (44).

He was discharged while in remission (45) on February 27, 1929, but three and one-half months later was readmitted for the third time (46), suffering from hallucinations (47), bizarre, hebephrenic behavior (48), with many somatic delusions (49). There was evidence of deterioration (51), and he continued on a steady downhill



course until his delusions culminated in his assertion that he was giving birth to a baby (50) on May 20, 1933. Two days later, he suddenly died from chronic valvular heart disease (52).

St. Elizabeths Hospital  
Washington, D. C.



## LIGATION OF THE ANTERIOR CHOROIDAL ARTERY FOR INVOLUNTARY MOVEMENTS--PARKINSONISM

BY IRVING S. COOPER, M. D., PH.D.

It is the purpose of this paper to report experience with a new operation aimed at the relief of involuntary movement disorders. This operation consists of ligation of the anterior choroidal artery. The rationale of this procedure lies in the fact that this blood vessel supplies most of the structures which have been attacked surgically in the attempt to relieve intractable involuntary movements. Among the structures irrigated by this vessel are the globus pallidus, ansa lenticularis, red nucleus, retrolenticular portion of the internal capsule, corpus luyisi, substantia nigra, optic tract and cerebral peduncle.

It is beyond the scope of this report to review the literature or describe the neuroanatomy or physiology of involuntary movements. Rather, it is only the purpose to call attention in a preliminary fashion to the early effects which have been noted following ligation of the anterior choroidal artery in cases of parkinsonian tremor. This operation was developed as a result of the unexpected disappearance of unilateral resting tremor in one case following the interruption and subsequent ligation of a vessel considered to be the anterior choroidal artery.

### CASE REPORTS

*Case 1.* W. T., a 36-year-old white man, had suffered from severe parkinsonian tremor associated with most of the other known symptoms of advanced Parkinson's disease for 18 years. This had become progressively more severe from the time of onset, and for 10 years the patient had been virtually disabled. As early as 1943, he had needed assistance to get out of his chair, and was unable to perform such usual simple tasks as feeding himself, or going to the bathroom. He was admitted to Kings County (N. Y.) Hospital in 1945 because he was unable to take care of himself. He stated that he would attempt suicide but was unable to do so. He was admitted to Central Islip (N. Y.) State Hospital in 1949. He was never able to stand or walk from the time of his admission to Central Islip.



Prior to operation this patient demonstrated constant, severe, alternating-type tremor of all four extremities, worse in the upper extremities. Speech was unintelligible. He had not been able to hold a pen or pencil to write for 10 years. He was a full-time nursing problem and had to be fed, bathed, clothed, and completely managed by the nursing staff. His left anterior choroidal artery was ligated through a left frontotemporal craniotomy early in 1953. Subsequent to this operation, although motor power was unimpaired, resting tremor, rigidity, and cogwheelism disappeared completely from the right extremities. The right anterior choroidal artery was subsequently ligated by means of silver clips through a right frontotemporal craniotomy. One week following this operation, the patient could get briskly out of a chair, walk rapidly without any evidence of festination gait, speak clearly, and voluntarily write the surgeon a full page letter by his own hand. There is practically no tremor, at rest, in either of the upper extremities. There is moderate tremor during excitement or emotional duress. Rigidity and cogwheelism are absent from all four extremities. Speech has become intelligible. The patient can feed himself, clothe himself, hold and drink a glass of water without difficulty, and attend to his excretory functions alone and unaided for the first time in more than 10 years. This improvement appears to be progressive to date. However, long-term results must await further observation.

*Case 2.* P. W., a 38-year-old white man, suffered a known attack of encephalitis at the age of 20. Shortly thereafter, he had the onset of typical postencephalitic parkinsonism. He had progressively more severe tremors, involving both upper extremities, oculogyric crises, and festination gait. Rigidity of all extremities was marked. The tremor became so severe as to require constant nursing care. Therefore, the patient was admitted to Central Islip State Hospital in 1944. His diagnosis at that time was postencephalitic parkinsonism and mental deficiency.

Early in 1953 the right anterior choroidal artery was ligated by means of silver clips through a right frontotemporal craniotomy. Since immediately following the operation, there has been an absence of rigidity and cogwheelism on the left. Resting tremor in the left extremities has been almost completely absent. The tremors return to a moderate degree during excitement. The tremors,



rigidity and cogwheelism of the right extremities have persisted. Motor power of the left extremities has improved as compared with the preoperative state.

Besides these two cases, which are cited very briefly and without detailed description, six additional ligations of the anterior choroidal artery have been performed. The early results obtained in all these cases have paralleled the postoperative findings cited in the foregoing. That is, following ligation of the anterior choroidal artery, there have been noted: marked diminution of contralateral tremor, disappearance of cogwheelism and rigidity from the contralateral extremities, and improved motor power in the contralateral extremities. The writer has not noted any instances of hemiplegia or hemianesthesia. Gross confrontation testing has not revealed visual field defects. Detailed visual field studies are in progress.

For the sake of brevity, many significant details have been omitted from this brief report. It has been the writer's purpose only to point out that surgical occlusion of the anterior choroidal artery can be accomplished safely and with apparently significant clinical and neurophysiologic results.

#### SUMMARY

Two cases of ligation of the anterior choroidal artery have been reported to illustrate the writer's investigative use of this operation. He has found, following ligation of the anterior choroidal artery, in cases of parkinsonism, a diminution or relief of the typical resting tremor in the contralateral extremities. He has not noted any instances of hemiplegia or hemianesthesia following this operation.

Central Islip State Hospital  
Central Islip, N. Y.



## EDITORIAL COMMENT

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### BORN UNTO TROUBLE

It seems to be a good idea on occasion, and a timely one on almost any occasion, to question whether all the apparent ills in the world are entirely unmixed evils.

Psychiatrists, like other humans, can look at one side of a fact so intently as to see little of another side. We think pain is a case in point. The physician is dedicated, by a great oath to the healing god, Apollo, to seek the benefit of his patients, in which objective the relief of pain has been comprised from time immemorial. Pain is plainly one of the "deleterious and mischievous" things against which the physician pledges himself in the Oath of Hippocrates; and, although the doctor may make daily use of a patient's pain in diagnosis, his orientation is all toward regarding it as an evil or a sign of evil. The psychiatrist in particular, engaged in endless struggle against mental suffering, may be likely to forget that from other than the medical point of view, pain may have important, or even essential, personal and social functions. We think occasional examination of those functions may have its uses.

Pain is one of those experiences which everybody has, almost nobody likes, and nobody can define satisfactorily. For a noble effort at definition—but one which nevertheless comes short of the goal—we may commend Josef Matfus' short study in the January 1951 issue of this *QUARTELY*; and one could compile an impressive bibliography of scientific books and articles on the subject. But we know of no truly definitive treatment of the phenomenon and of none that may be considered both reasonably comprehensive and reasonably objective. Pain is too personal and too subjective an experience for direct comparison from individual to individual, or for the sort of direct measurement one employs in reading a temperature, doing a blood chemistry, or determining a person's rate of basal metabolism.

Pain is another of those subjects that one is compelled to discuss without knowing with any great degree of certainty just what is being talked about. Consider the dictionary's difficulties. Webster says, among other things, that pain is a "form of consciousness . . . varying from slight uneasiness to extreme distress or



torture." But "uneasiness" is a state of being "disturbed by pain"; "distress" is the "pain of suffering"; "torture" is extreme pain. "Torture" is also "torment," and "torment" is, besides being "agony," "that which gives pain." And "agony" is "anguish," and both "agony" and "anguish" are "extreme pain." So we might as well hold our hats; here we go again! Or, perhaps, like the Tentmaker, we have already arrived, coming out by that same door where in we went.

Pain is a phenomenon almost perfectly adapted to illustrate the philosophical proposition of solipsism: "that the self knows and can know nothing but its own modifications," or, as Webster adds, the "inaccurately" derived conclusion "that all reality is subjective. In this respect, pain is not unlike psychosis. One of the recognized great in the psychiatric world had a brief psychotic episode in his old age—with hallucinations and delusional ideation—in the course of an organic illness. He was pleased, on recovery, with the additional insight the experience afforded. "Now I know," he wrote to a friend, "how my patients have been feeling all these years." But how can one truly know such a thing? We are inclined to think that man's capacity for various degrees of identification with his fellows is as important for human progress as is any other human attribute; but even he who identifies most fully, he who comes nearest to assuming the feelings and thoughts of another person, is carrying his own emotional, experiential and intellectual equipment into the identification process with him. We take to ourselves another's joy or grief, or fright or rage, on our own terms; or, for all practical purposes, we must assume that we do.

So with pain! One cannot measure subjective (hallucinated) voices accurately in terms of decibels. And the scale of dols, by which we attempt to measure pain intensity as we measure noise intensity in decibels, is based on criteria so subjective that one wonders if reports can ever be really comparable or data reliably standardized. We are not sure whether it was medical school or psychology class that originated the plaintive masculine inquiry to the women who had just agreed that childbirth was the most painful experience in the world: "Pardon me, ladies, but has either of you ever been kicked in the testicles?" All discussion of the castration complex aside, one wonders how even the best modern techniques, devised and administered by the most careful workers,



can ever make accurate comparison possible of the grossly different types of pain occasioned by sex differences—let alone between grossly similar types where the individuals concerned have no sex differences.

A physician notes the case of a patient, a football player with a fractured clavicle, who reported that he had not—neither then nor ever—ever felt “pain.” What sensation the man had instead, or whether he denied having any, is not reported. Could the problem be semantic, with whatever sensation the patient did have simply not identified by him with the word “pain”? Or was there a true lack of sensation, in which case, how had the man survived cuts, burns, scalds and infections long enough to reach the football-playing age?

In the present discussion of pain and its personal and social implications, we are using the term in its ill-understood general sense. We are calling “pain” any one of the sensations, physical or mental, that we think the average person would call “pain”; and we are largely concerned with matters that have been generally recognized as painful—though not necessarily in the modern scientific setting—from time immemorial.

The survival value of pain to the individual is one of those facts which ought to be self-evident. Gladys Bevans, who is generally considered an authority on the subject of bringing up children, and who is well-recognized as an exponent of the school of understanding, tolerance and gentleness, remarked in a recent newspaper column that in these days of gas stoves and automobile traffic, painful punishment—when there is no chance to reason—is to be preferred to a child’s death by accident. It seems to us that this is a very practical point and one which some of the newer schools of child-rearing have not countered satisfactorily. The value of pain as a life-saver is implicit in such ancient observations as that burnt children shun fire and that people once bitten are twice shy, while it is invoked as a socializing instrument in such admonitions as the warning not to spare the rod lest one spoil the child—a procedure we disagree with emphatically, but one illustrative of an important relationship.

Pain is probably an invariable accompaniment of birth and is a frequent accompaniment of death; physical pain of one kind or another must have been an almost ever-present factor in the life of primitive man; and physical or mental pain may be ever-present



in the lives of unfortunate individuals anywhere in the non-primitive world of today. The unpleasant aspects of pain have probably been as important as any other single factor in teaching man to minimize the physical risks of life and so increase his chances of continuing to live, and to minimize the risks of social life and so increase his chances of continuing and developing social living.

Pain as a social institution in itself was established in the mists of man's remotest antiquity. Pain was a prerequisite to initiation into manhood, and often into womanhood, in the vast majority of "primitive" societies known to the science of ethnology—although one may question here the use of the term primitive, since all of them must have had tens or hundreds of thousands of years of fully human evolution behind them before science made their acquaintance. Circumcision, subincision, ceremonial defloration, the knocking out of teeth, the amputation of fingers, the deliberate deformation of the skull, tattooing, human sacrifice, were all expressions of a human impulse to inflict or suffer pain that must have been universal. If one could find lower mammalian examples—and it is true that the males of most species fight each other for the females, that life for most wild animals must involve much injury, hunger and other suffering, and that many students think elements of cruelty invariably enter into the animal sex act—one could almost postulate a genetic impulse for some of man's most painful practices. Biological or not, we can be certain that pain has been a (perhaps necessary) accompaniment of human socialization from the most ancient times. Man has always experienced, and he cannot today avoid, the traumata of birth and weaning, which, incidentally, he shares with the higher animals.

The existence in remote times—we think—of purposely created pain, with its results of fear, anxiety and other unpleasant human reactions and emotions, has been a major force in socialization and progress. Physical and mental pain have been used to force compliance with social rules and regulations, while many of society's organized efforts have been devoted to the alleviation of such avoidable pain (as from cold, hunger, illness) as has not been purposely employed. The science of medicine and the specialty of psychiatry are dedicated, and always have been so, largely to the relief of pain, psychiatry to relief of that pain which we believe to be the worst of all, the pain of emotional or mental suffering. Almost the whole of the rest of man's science and technology has



been employed directly or indirectly toward the lessening of human pain, by increasing facilities for positive enjoyment of life and by minimizing the risks of life.

But men are, by emotional and intellectual necessity no less than by environmental pressures, risk-takers. If life held no risks, we would have to invent some. And risk-takers cannot avoid all pain. And there is the pain not connected with voluntary risk, the pain of the mental derangements with which psychiatry deals, for example. We employ the operation of pre-frontal lobotomy in certain cases of such pain. It appears to reduce the patient's appreciation of both physical pain and the pain of anxiety. But in considering this result, we must consider also the possibility of the undesirable complications known as post-lobotomy personality changes; and, in attempting to evaluate what we have done, we must note again that we may not be reducing pain itself, but merely appreciation of it. This may be a distinction without appreciable clinical difference; clinically, the relief of pain and the relief of appreciation of it may amount to about the same thing; but the lobotomy sequelae are an uncommonly good illustration of the fact that in undertaking pain relief, it is difficult to be certain of what we are doing.

In the relief of emotional and mental pain, we have found no way to avert all of the suffering caused by such universal traumata as weaning, sibling jealousy and the shattering experience which, misnamed or not, and biological in origin or not, we find it convenient to call the Oedipus complex. Medicine has, in fact, been much less successful generally in relieving mental or emotional pain than in relieving physical discomfort. The narcotics can eliminate or greatly lessen the physical pain of a cancer; but mental specialists have not been notably successful in relieving the mental pain that is born of the anxiety and the fear of death and helplessness caused by cancer. Similarly, we think that those concerned with the new specialty of gerontology are having more initial success in the treatment of the physical aches and pains of old age than in treating the emotional pain which generally accompanies the aging process.

What we are wondering about here, however, is not the relief of pain, but the question if—in preoccupation with relieving and avoiding pain—there has not been a tendency to lose sight of the fact that pain does have certain values, in individual survival and



in social and psychological consequences, and if there has not also been a tendency to lose sight of the fact that there are other time-tested methods of coping with pain than relieving it. We have in mind in particular what has been considered from ancient times the virtue of stoicism, fortitude, the quality the army has long called "guts," the age-old counsel that when pain is unavoidable the thing to do is "grin and bear it." It should be said, plainly, emphatically, and without quibble here, that what we are advocating is, to the best of our knowledge and belief, and taking into full account the unconscious impulses we must share with mankind in general, neither sadism nor masochism. We are emphatically not of any school that considers it virtuous or normal for man to take pleasure in inflicting or undergoing pain, physical or mental; and, in particular, we consider man's proneness to what Bergler calls psychic masochism an affliction calling for all our efforts in treatment and prevention. Rather, what we are trying to say is that man is born unto trouble (as the sparks fly upward), that sometimes the most practical way to meet suffering is to set one's teeth and endure it, and that sometimes this is the best way to meet it, as well as the most practical.

We think most people know all this but are inclined to be neglectful of it. After all, most of us were brought up, among other maxims, on "What can't be cured must be endured"; and we think it might be intelligent to repeat this oftener to ourselves, and oftener to our children. It is probably more "natural" to weep and give way than to withstand silently and boldly. Judging from our physiological reactions, it is at least as "natural" to flee terror as to confront it. It is certainly easier to scream or moan than to bite on the bullet. It is easier to run than to fight, easier to avoid risk than to risk hurt. It is easier to vegetate than to chance an injury in some enterprise. But very often the easy way is not the better way—or in the long run even the more comfortable way. And, fortunately for human progress, it is very often not the human way.

As workers in modern science, as well as ordinarily intelligent observers, we are inclined to think the human race may be entering its dangerous age, and that people are going to get hurt in it. The atomic era opens a new world for our children and our children's children's children; and we can be sure it will not be a safe one in respect to life and limb—at least not for ages. Science is



not being advanced for the timorous; the experimenter will always have to test the theorist's conclusions; and human lives may some day depend on such strange things as whether distance to the Great Nebula of Andromeda has been measured accurately—that is within a few thousand parsecs; or as to whether the penetrating power of this or that death-dealing X-particle has been calculated correctly for this or that protective material within a safety limit of half a dozen micromillimeters. Since we are not prophets, astronomers, nuclear physicists, or even science fictionists, members of all four professions may amuse themselves with these illustrations if they will; we do not pretend to guess the terms or the concepts of the science of the future; but we are completely certain that fingers will be burned in playing with it.

We believe this adds some present urgency to a question that should be timely anyway: Is our attitude toward pain—as implied and expressed in our medico-psychological endeavors—either the most appropriate one under present and foreseeable circumstances, or could it ever be appropriate for mankind at all? The tendency to assume that pain is an evil under all circumstances and the efforts to avoid or alleviate it under nearly all circumstances represent a wide drift from our own pioneer attitude of a generation or so ago, and from the traditional attitudes of the peoples who laid the foundations of western civilization.

We think there is a great deal to be said for our ancestors' viewpoint. Some physical—and perhaps much more mental—pain is the unavoidable lot of man at all places and in all times. We think man should be prepared to endure such unavoidable pain and unavoidable painful experiences with more fortitude than the doctrine of alleviation suggests. We do not suggest the revival of the ordeal for youth reaching manhood, or the revival of other painful initiatory experience, although, besides the superstitious and sadistic elements involved, there were matters of value in some of these practices—since it is well for youth to understand and be prepared for the things youth must actually experience.

To be hurt is not always something that at all costs should be avoided. Grish Chundar, the Bengali, in Kipling's tale, *The Finest Story in the World*, tells the Englishman: "I am afraid to be kicked, but I am not afraid to die, because I know what I know. You are not afraid to be kicked, but you are afraid to die. If you were not, by God! you English would be all over the shop in an



hour, upsetting the balances of power and making commotions." Leaving the question of being afraid to die, which, as Kipling himself would say, is another story, not being afraid to be kicked is the key to adventure, colonization and empire. Our fathers, our grandfathers and the elders among ourselves were brought up on tales of human fortitude and human suffering. The crew of the *Nancy Brig* spent so and so many days at sea in an open boat; they starved, shriveled under the sun, went mad from drinking salt water and urine—but some survived. A pioneer's leg was crushed; he could not get help; he applied a tourniquet himself, filed the back of his hunting knife into a crude saw, cut off the flesh, cut through the bone with his home-made saw, heated the knife in his fire and cauterized the raw flesh when the blade was red hot—and he survived. The Indian sneered, sang, boasted, or was impassive under torture. The pioneer white man emulated him.

We do not decry the splendid efforts made all through the history of our culture to minimize man's chances of being hurt and to minimize the risks of disease, untimely death and crippling injury. In these efforts medicine has played a splendid part. The mere fact of living no longer exposes western man to the risks of the black death or Asiatic cholera, or to serious risks from typhoid, typhus, diphtheria, smallpox or malaria—all former scourges of the earth. Modern sanitation under medical direction has reduced vastly the risks of other disorders; and there are prospects for the conquests of such ills as poliomyelitis, tuberculosis and at least some forms of cancer, though our generation may not live to see all these.

Progress in social organization, too, has lessened the risks civilized man runs from such varied sources as general ignorance and criminal elements. Twenty-five years ago, in fact—and until Hitler demonstrated once more that man's greatest danger is man himself—it looked as if mankind could at least map a way toward the eventual elimination of the risks that could then be identified, including warfare. As technology advanced, the conditions of living were becoming safer.

But as technology has advanced further, no man, or no institution, is now safe. We presume few persons, even under the most favorable conditions, have ever wanted a completely riskless world. If any ever did, we think the chance for it disappeared forever, or maybe only for a few millennia, on July 16, 1945 at Alamogordo in



New Mexico. Man put his hands that day on a force which, if he does not destroy himself with it, he is certainly going to use in attempts to explore the universe in one way or another; and we may be certain that he will either succeed or will continue trying for the allotted span of his species upon the earth. There were already, besides unavoidable risks man must take, avoidable ones he must also take because he is man. There are many more such avoidable risks now; and the unavoidable ones have been multiplied many-fold.

We think we would do well, considering what lies before us, to attempt more in the way of teaching men to accept risks and endure pain with fortitude. We think that, in the entirely proper aim to relieve man from unreasonable fear and anxiety, there may now be failure to emphasize sufficiently the human need for the ancient qualities man must have to face adversity. We think we may need, in a rapidly changing world, a little less emphasis in our mental hygiene programs on security and a little more on the conscious and teachable virtues of stoicism and fortitude. And we say this with full recognition that emotional security on the unconscious level may be a prerequisite to the development of real courage on the conscious level.

It is not impossible that a slight change in outlook might also have benefits more immediate than in the speculative atom-age future. Such a change might help, for instance, if we as a nation go to war again, to distinguish better between cowardice—which we take to be a yielding to conscious fear of the sort which men can be trained to face—and the unconsciously-based neurotic symptoms which properly call for psychiatric, not disciplinary, attention.

We think man needs courage to face the future now, and that our children will need infinitely more of it. Nobody need fear for, or make apologies for, the members of our present generation who have faced a world war that was terrible almost beyond conception, and who faced it with all our ancestors' courage. But we think we need more of their quality; and we think we can breed more of it, by teaching it again as a virtue—as our forefathers did—and resisting those who would decry all heroism as childish exhibitionism.

We don't know where the atomic era is going, but we are well on our way; men are going to take risks because the risks have to be taken, and other risks just because men are men. A lot of us are going to be hurt, and we may as well ready ourselves and our chil-



dren for it. We think whatever is done educationally (in the way of mental hygiene) will have to be planned with great care. The good in fortitude and the evil in cruelty are less easily distinguished than they are readily mixed. The bloody path of cruelty leads back to the earliest annals of man; the urge for cruelty may even be biological. One of the oldest of mankind's social records is a cave-painting, attributed to the Aurignacian period of the Old Stone Age and found in a cavern in northeastern Spain. It may be 20,000 years old or older; and it depicts a ceremony which certainly ended in a bloody bacchanalia of human sacrifice. Sadism, or more likely, masochism, is evidently older than any civilization we can trace. And we think today's careless, ignorant or perverted teacher of stoicism can easily preach brutality instead. Humanly—not psychiatrically—speaking, we all know brutes who can't distinguish between brutality, bullying and fortitude, and we want no such teachers, though some of them are far from being the worst of men.

But in working for greater emotional security for our children, it is easy to over-reach; it is easy to confuse emotional with material security; the world is infested with infantile adults who insist on being babied by their families, by benevolent organizations, or by the state. In any reorientation of teaching there is risk. We think moderate reorientation here is a warranted risk, one as well worth taking as others we and our children will be forced to assume. And we think, even if teaching occasionally goes wrong, that it will be easier to meet occasional increased brutality with increased courage than to meet other foreseeable risks without it. At the onset of an era, man can no longer build for the future on the assumption of an even doubtfully-stable world. Man must, if he is to cope successfully with his multiplied problems, plan instead to meet the unpredictable hazards of unpredictable change with increased bravery to dare, stoicism to endure, fortitude to withstand. We shall never be lost as long as we can carry with us into the future the guiding light that is man's finest inheritance—the courage of his ancestry.



## BOOK REVIEWS

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**Ego Psychology and the Psychoses.** By PAUL FEDERN, M. D. Edited with an introduction by Edoardo Weiss, M. D. 375 pages, including index. Cloth. Basic Books. New York. 1953. Price \$6.00.

The late Paul Federn was a patriarch of the psychoanalytic school. He was a great scientist and a noble personality. Much of his work was many years in advance of his time, and much more of it has been basic to modern progress in psychoanalytic achievement. Federn was a faithful follower of Freud and a daring and unconventional innovator. At a time when Freud himself believed that the psychoanalysis of psychotics was impossible, Federn pioneered in the analytic treatment of these people. His work in ego psychology was fundamental, and his concept of ego boundaries one of the most fruitful that has been advanced for the investigation of personality.

The present work, *Ego Psychology and the Psychoses*, represents selections from his numerous published papers, collected and edited after the author's death by Edoardo Weiss, a pupil of Federn and a close friend for more than 40 years. The papers collected herein cover briefly the field of ego psychology, a longer discussion of the treatment of psychoses, and two of Federn's important papers on narcissism. Some of the collected material was published previously in this *QUARTERLY*, the first important scientific writings by him since he came to America in 1938.

This reviewer thinks this work one of the most important contributions to psychiatric literature in many years. Its content ranges from material which the psychiatrist in general will find illuminating theoretically, to notes on technique which should be of vast importance to the practising analyst. Most of the number of practitioners reporting successful psychotherapy with psychotics today owe much in the way of basic concept or of procedures to Federn. *Ego Psychology and the Psychoses*, as a development on Freud's basic concepts, belongs with the works of Freud himself among the indispensable foundations of any adequate psychiatric library.

**The History and Development of Neurological Surgery.** By ERNEST SACHS, M. D. 158 pages. Cloth. Hoeber. New York. 1952. Price \$5.00.

The 36 pages of bibliography constitute the main reason for parting with the money to obtain this book. The presentation is interesting and covers all periods of neurological surgery from the ancient trephinations of the skull to recent developments, but the coverage is on the superficial level. Those interested in having a short handbook will find this a valuable one, but the treatment is far from being adequate for any more than a general introduction to the subject.



**Range of Human Capacities.** Second edition. By DAVID WECHSLER, Ph.D. vii and 190 pages. Cloth. Williams & Wilkins. Baltimore. 1952. Price \$4.00.

In this book, Wechsler presents his thesis that the range of human capacities is exceedingly small, that there are calculable limits to human variability, probably biologically determined, and that these limits have the characteristics of natural constants. Using data for physical traits, physiologic and metabolic functions, and some psychomotor, perceptual and simple intellectual traits and abilities, he has devised what he calls the total range ratio. He defines the total range ratio as the "ratio between the highest and lowest, the least and most efficient individual of a measured population with respect to any measurable trait or ability, where the highest and the lowest are defined as the 2nd and the 999th individual in every thousand, respectively." He has found in the data examined that the ratios between the extremes of ability have strikingly recurrent values which fall mostly within the range 1.2:1 to 2.5:1.

This edition differs from the first edition, published in 1935, in the addition of two chapters, one dealing with the span of life as a human capacity and the other on range in productive operations. The chapter on the effect of age has been expanded. The book is an interesting attempt to discover constants in the field of human capacities. The speculations and procedures used should be of interest to those who find the question of variability in the human organism a provocative one.

**Sigmund Freud.** By RACHEL BAKER. 172 pages. Cloth. Julian Messner, Inc. New York. 1952. Price \$2.75.

This is an enthusiastic, though completely naïve attempt at a biography, written with inadequate knowledge, thus conveying an erroneous impression. The book is outdated, and could have been published around 1900. The simplification of Freud's ideas is carried to the point of caricature. It is regrettable that much, though superficial, effort and good will are wasted.

**Weeping Bay.** By JOY DAVIDMAN. 257 pages. Cloth. Macmillan. New York. 1950. Price \$3.00.

This is a hopelessly depressing book, written with good intentions. The topic is the tragically anachronistic society of the poorest of the poor on the Gaspé peninsula, inhabited by French Canadians. The author dwells on this misery; but as a novel, the book miscarries. It is inadmissible, this reviewer thinks, to substitute, for psychological development in a novel, a dramatized sociological treatise, especially when external circumstances are mostly held responsible.



**Diagnostic Electroencephalography.** By HANS STRAUSS, M. D., MORTIMER OSTOW, M. D., Med. Sc.D., and LOUIS GREENSTEIN, M. D. xiv and 282 pages with 46 figures and 61 tables. Cloth. Grune & Stratton. New York. 1952. Price \$7.75.

The layout of this book is such as to allow easy and rapid reference to particular subjects. The table of contents indicates the logical order of the text. The index is fairly complete. The bibliography consists of 17 closely-packed pages. The illustrations are grouped together for easy comparison of the electro-encephalograms.

It is the opinion of L. M. Davidoff in the foreword that, with present knowledge, clinical application of the electro-encephalogram (EEG) may be restricted to a "certain limited group of neurologic diseases."

In Part I, the authors describe the equipment and its application to get reliable recordings. In the many years of experience at Mt. Sinai Hospital, they have set down more rigid standards, differentiating the abnormal from the normal EEG, so that fewer false-positive reports are made. Thus, the readings become more valuable. Provocative tests and physiological correlations are discussed conservatively.

In Part II, the EEG's of numerous organic and functional diseases are described separately. In Part III, the same conditions are examined from a diagnostic point of view. The records are described, classified, and interpreted physiologically, and finally clinically. Numerous cross-references within the text eliminate considerable repetition.

Because of the authors' conservatism, considerable experience, frank discussion and clear exposition, this book is recommended to those who wish to use the technique and who wish to learn to interpret the electro-encephalogram.

**In the Name of Science.** By MARTIN GARDNER. 320 pages, including index of names. Cloth. Putnam. New York. 1952. Price \$4.00.

This is a primer of "crank" scientific literature. Mr. Gardner herein reviews the field of screwball science from Dowie to Dianetics. He covers in outline form a great deal of pseudo-scientific material.

This book can be recommended as a guide for general reading for anybody, layman or scientist, who is interested in mapping the dangerous territory where unscientific concepts are presented in pseudo-scientific form. The one drawback to an otherwise fascinating and useful volume is that the author may have included too much. This reviewer thinks it regrettable that the author should have included—*notwithstanding* apologetic explanation—a chapter on Rhine's ESP and PK experiments. His discussion of handwriting analysis and drawing tests is, however unintentionally, definitely misleading, and the listing of such people as Korzybski, Moreno and Reich also seems regrettable.



**The Wayward Ones.** By SARA HARRIS. 220 pages. Cloth. Crown. New York. 1952. Price \$3.00.

The author presents in the form of a novel the day-to-day life of an institution for adolescent delinquent girls as experienced by one girl from the time of her commitment until the completion of her training period. Miss Harris is a former staff member of such a school.

In an attempt to point out the weaknesses and inadequacies of the institutional program, she draws a highly exaggerated picture, painting the institution in such a way that one supposes life is rife with perversion in such a setting.

The author offers no positive formulations or suggestions for improvement, although one would hope that an individual who has had an opportunity for such an invaluable first-hand experience would channelize her criticism toward a positive direction. At the same time, perhaps magnification of the ills and problems of this type of institution will alert competent workers in the field of juvenile delinquency to objective examinations.

**Rabelais.** By JOHN COWPER POWYS. 424 pages, including index. Cloth. Philosophical Library. New York. 1951. Price \$3.75.

A distinguished author and literary critic sets out here to do justice to one of the much-maligned great. Rabelais is a dirty word to many moderns; and many who are better informed still have a distorted view of one of the world's great figures because his best-known translator into our tongue happened to be a man of genius himself, with a strong sense of broad humor of his own and little sense of the obligation to be literal. Powys here discusses the translation difficulty, presents a short history of one of the sixteenth century's most fascinating characters, and adds some of his own translations of bits of Rabelais.

The book closes with an interpretation of Rabelais from a number of different angles in which Powys shows a considerable degree of insight and suggests the existence of material very well worth psychiatric study. The reviewer would recommend this work to everybody interested in the genesis of modern literary expression and of modern culture.

**Race and Culture Relations.** By PAUL A. F. WALTER, Jr., Ph.D. xi and 482 pages. Cloth. McGraw-Hill. New York. 1952. Price \$5.50.

Designed as a text in sociological anthropology, this book studies the races that inhabit the various countries and regions of the world, with particular emphasis upon the influences and cultural relationships of minority groups. The approach is explanatory and objective, and there is little attempt to enter into the dynamics of the problem.



**Understanding Your Migraine Headache.** By CARO W. LIPPMAN, M. D., and MARGARET LIPPMAN. 150 pages. Cloth. Greenberg, Publishers. New York. 1952. Price \$2.50.

"After twenty years of clinical work with migraine I have come to realize that it takes a migrainoid to really understand a migrainoid. Migrainoids seem to talk a language of their own. . . . My fair collaborator knows more about migrainoids than I do. She was, and is, a migrainoid who, through understanding and treatment, has found a way of life. She has achieved happiness and contentment, and I, in turn, have benefited thereby. . . ." Because of these experiences ". . . we offer a record of our exploration together into a strange, bewildering, and often amusing migrainoid world."

From this, it would appear that the Lippmans have a background of experience sufficient to give hope to the person who suffers from migraine, but one wonders if they have not identified too many "migrainoids" (a word coined by the authors) by investigation among lay persons. Too, one wonders if it had not been wiser if the authors had used a more scientific method of investigating the problem of migraine and if the authors, before giving their information to the public, had presented their investigations to doctors who have studied the problem.

Medical literature does not lead one to believe that *real* migraine or hemi-crania is such a common illness as the authors would lead one to think. Medical literature agrees that real migraine is difficult to diagnose and to treat, that persons with real migraine have prodromal and/or substitutive (equivalent) symptoms, and that such persons have neurotic or emotionally unstable backgrounds. But are all neurotics "migrainoids"? The authors do not state that every one of the persons they have written about has had a real migraine condition before or along with the symptoms noted. This does not mean that the authors are talking "through their hats." No, indeed, they may be entirely correct. But they have not investigated their ideas properly. They have been too fast in presenting their ideas to the layman.

Chapter one starts off with a list of questions such as, "Do you hate to get up in the morning? . . . Do crowds annoy or tire you? . . . Are you absent-minded? . . . Are you a picture-straightener? . . . (etc.)" Then follows, "Check the above questions. If you answer 'yes' to fifteen or more, it's a pretty sure bet that someone in your family has sick headaches. That makes *you* a migrainoid. A migrainoid is a person who has inherited *the migraine factor*. . . . Twelve million Americans are known to have migraine headaches. For each of these, possibly two others have migraine, although they may not be aware of the fact. That makes around thirty million migrainoids. . . .



"A study of migraine is a study in paradox. The migrainoids are normal people who, because of their chemical inheritance, often *appear* to be abnormal. One may have a 'typical headache'; another may go all his life with no headaches. One may be a fussy, immaculate perfectionist; another will be a 'Sloppy Sue' or 'Dirty Dan'. . . . He may be cheerful and optimistic one hour and depressed and discouraged the next. . . . The migrainoid sees things that are not there, hears sounds where no sound exists—or he may not see anything around him and be impervious to the loudest sounds. In the morning he may feel like death; by nightfall he is bursting with health and vitality. He may sleep while others work and work best while others sleep. He is a puzzle to himself and to everyone around him. . . .

"In summary, then, migraine is not 'just a headache'. Headache is the most commonly recognized symptom, but 'migraine equivalents' are as common as the classic headache. . . ."

In their final chapter, "Treatment," the authors mention vitamins, analgesics, hypnotics and ergotamine derivatives as palliative treatment and as preventive treatment. "It has been found that *alpha-estradiol benzoate in sesame oil* is the most effective form of estrogen to be used in treating women migrainoids. *Testosterone propionate in sesame oil* has proved the most effective androgen for treating male migrainoids."

**Psychiatric Aide Education.** By BERNARD H. HALL, M. D., MARY GAN-  
GEMI, R. N., V. L. NORRIS, A. B., VIVIENNE HUTCHENS VAIL, A. B.,  
P. A., and GORDON SAWATSKY, A. B., P. A. xvi and 168 pages. Cloth.  
Grune & Stratton. New York. 1952. Price \$5.75.

This book describes a program of the Menninger Foundation at Topeka State Hospital for the training of psychiatric aides. While there are undoubtedly advantages to the program, which devotes a year exclusively to training, there is the question of fitting trainees into positions commensurate with their abilities, and, perhaps more important, finding positions that will pay a salary to make the training attractive. From the follow-up studies done, those students who have graduated so far have done rather well—but would this hold true of large numbers of graduates?

Since the object of the course is not to train toward charge positions but simply to give training for a position as psychiatric aide, the graduates will be placed in the position of either taking charge positions, for which they are not necessarily prepared or suited, or of working for salaries which they could easily obtain in other fields without training. These comments are not meant to imply any dislike on the part of the reviewer for the program—they merely imply a skepticism as to its practicability.



**Psychanalyse et Biologie.** By MARIE BONAPARTE. 190 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 400 fr.

**Psychanalyse et Anthropologie.** By MARIE BONAPARTE. 190 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 400 fr.

Marie Bonaparte has been associated with the French psychoanalytic movement from its early days. As one of Freud's pupils she was asked to write an article about works of the Austrian psychiatrist when he was on his way from Vienna to London in 1938. The article, published in the first book mentioned, shows how the author has engaged herself in the struggles both for the recognition of psychoanalytic theory and for the stabilization of the theory of primary phenomena through the successive modifications that Freud himself has brought to his original ideas.

The books are edited with the purpose of collecting papers written between 1933 and 1948. Some of them are barely related to the fields mentioned, namely, biology and anthropology. "The Legend of the Fathomless Waters," "A Lion Hunter's Dreams," and "Notes on the Analytic Discovery of a Primal Scene" appeared in American journals. Others would gain deserved recognition if translated. This writer would like to mention the paper on Saint Christopher, patron saint of the motorist, published in *Psychanalyse et Biologie* and three published in *Psychanalyse et Anthropologie*: "The Case of Mrs. Lefebvre," "On the Symbolism of Trophies of the Head," and "On Aggressive Autoeroticism of Tooth and Nail."

Discussing data concerning a theory in its evolution, as psychoanalysis has proved to be over the past 50 years, one needs a continuum in elaboration which is not a purpose of these books. However, one can select passages which seem to represent the ideas of the author.

In the book on psychoanalysis and biology, Marie Bonaparte uses terms in a very broad sense. "Psychological data are, as well as the physiological ones, biological data" (p. 5). There is a center or a nucleus where both disciplines meet. Reaching this level we are confronted with many differences of opinion. The author, mainly through the study of female psychosexual development, has come to conclusions, some of which are as follows:

1. "I believe that there exists an organic unconscious" (p. 164).
2. "The antagonism between the integrated personality and the perpetuation of the species is potentially present at the paleobiological stage" (p. 36).
3. "The origin of anxiety is anterior to and independent of any kind of super-ego." (p. 34).
4. "Hunger is more or less satisfied in our society but not the sexual instinct. This fact makes the latter the psychological instinct par excellence."



5. "The biological reaction to the sexual instinct is more pronounced in the female than in the male" (p. 20).

These few excerpts exemplify the labored development of the young science. They are subjects of controversy. Some of these data have been elucidated since. Others remain in the scope of investigative procedure.

This reviewer finds the book on anthropology of greater interest to the contemporary reader. The author believes in a parallel between ontogenesis and phylogenesis. She agrees with Freud on the ubiquity of the Oedipus complex. She presents material collected by herself and others in an organized form. One feels that basically she differs little in her approach from Róheim's methods. Developmental processes on a phylogenetic basis are divided into three stages: animism, totemism, and science.

Both these publications are provocative and worth reading. They demonstrate the continued interest of the author in what psychoanalysis can contribute to other sciences. There is reflected an awareness of the limitations of psychological understanding of biological phenomena, partly because of an initial, overrated goal given to the young science. One questions the fact that this latter attitude was common to most analysts. "The psychoanalyst . . . is a patient and conscientious scholar who . . . has to recognize the eventual limitations put by nature itself on his own power."

**The Psychology of Learning.** By JAMES DEESE. 398 pages including index and bibliography. Cloth. McGraw-Hill. New York. 1952. Price \$5.50.

In the author's words this is a textbook "broad rather than exhaustive, that attempts to survey all the present-day problems in the psychology of learning." The book is recommended by this reviewer as a good survey of this important area. The author, who is assistant professor of psychology at the John Hopkins University, has written a clear account of the basic concepts of learning theory. He has also dealt with the contributions of learning theory to complex clinical problems such as experimental neurosis, conflict and motivation.

The first part of the book is concerned with the basic problems of reinforcement, extinction, motivation, and punishment. Following this are chapters dealing with examples of multiple-response learning. The third part discusses special topics, such as individual differences, emotion and learning, and the neurophysiology of learning. The author also devotes a chapter to current theoretical problems.

The book strikes a good balance between research findings and their applicability to everyday problems of learning. Recent developments and experiments are well discussed and integrated with the earlier classical experiments. The style of the writing is clear and interesting. An extensive bibliography is furnished.



**Limbo.** By BERNARD WOLFE. 432 pages. Cloth. Random House. New York. 1952. Price \$3.50.

*Limbo* is a brilliant satire on the post-post-atomic world, around 1990, written with rare psychological insight, skill, dry humor. The satire is on many levels, the most important target being the terminal misuse of psychic masochism. A brain-surgeon during World War III, escapes to an uncharted island, leaving his diary behind him; the diary is written in a disgusted-sardonic mood despairing of humanity. His remarks are taken up by a politically-minded friend who promotes them as new dogma. Thus, masochism becomes state religion; amputeeism—voluntary “amp”—the social standard.

Unfortunately, the science of prosthetics progresses, too; the result is that the new limbs are better equipped for World War IV than the natural ones. The description of the imaginary society is hilariously funny; the satire extends to social, sexual, philosophical problems as well. The satire is also a severe indictment of totalitarian thinking and acting.

*Limbo* is one of the rare books permitting the reader to have a really good time from the beginning to the end of the narrative. It is somewhat reminiscent of Swift's famous *Modest Proposal*, though in a highly modern version.

**Look in Your Mirror.** A Study in Human Behavior. By JOHN POTTS, M. D., D. C. L. 201 pages. Cloth. Vantage. New York. 1952. Price \$3.00.

Each person, as he grows old, regrets that he is unable to pass on to someone the experience, the knowledge, the ideals of living which he has learned. In a pessimistic mood, he sometimes wonders if his living has been of advantage to society. He wonders if he has made his contribution or paid for the privilege of being born.

It seems that Dr. Potts has felt this way and that he has wanted to inform others of his ideals and suggest to them ways of attaining happiness through self-understanding. He writes in a homely but very pleasing style. He makes no effort to be “scientific,” and, for this reason in particular, his book will become popular reading for the average person. It should, therefore, be recommended for public libraries.

**The Treatment of Injuries to the Nervous System** By DONALD MUNRO, M. D. 284 pages including index. Cloth. Saunders. Philadelphia. 1952. Price \$7.50.

When *The Treatment of Injuries to the Nervous System* was reviewed in the January 1953 issue of this QUARTERLY, the price was not mentioned. The publishers now supply the information that it is \$7.50. The QUARTERLY's reviewer found the book “an excellent, concise guide to the do's and don't's of treating nervous system injuries of all kinds.”



**Disorganization, Personal and Social.** By HERBERT A. BLOCH. 607 pages. Cloth. Knopf. New York. 1952. Price \$5.00.

Evaluation of the diverse methods used in the social sciences and the random, indiscriminate collections of facts which have been achieved compelled the author to attempt an integrated theory which would give a more coherent picture. He attempts to tie together anthropology, psychiatry, psychology, sociology, et. al., at the point at which they all converge—the social individual.

The social individual is studied as he refracts the cultural needs, tendencies and lags. As the hub of the wheel on which cultural movement proceeds, the social individual consists of the vital interrelationships between his inner self and his social milieu. There is postulated a parallel development of personal and social disorganization. These diverge from and mingle with the main stream of basic needs and process changes.

Every effort is made to lay the foundation for an effective objective evaluation of key contemporary social problems of disorganization. The theory developed in the first section of this easy-to-read textbook is applied to the facts and individuals involved in delinquency, sex offenses, drug addiction, mental deficiency, suicide, and other social problems of current concern. The individual's interrelationships with the underlying cultural conflicts and the social discord, both of which are inherent in the social structure, remain always in the foreground.

**The Psychology of Religion.** By L. W. GREENSTED, D. D. 163 pages. Cloth. Oxford University Press. New York. 1952. Price \$3.00.

In this book, Dr. Greensted, who is canon emeritus of Liverpool, England, and a fellow of the British Psychological Society, expresses his views relative to the value of psychological theories in the understanding of religion. He reviews and interprets the various schools of psychology and quotes many persons who have molded the understanding of religious beliefs. However, he believes that there is still a big gap in a clear understanding of what one means by religion; that neither psychology nor theology has answered all the questions. He believes that there is something in the nature of man which is beyond the understanding which psychology and theology can give; that this nature is modified but is not wholly changed simply through a thorough understanding of theological or psychological theories and facts, for, "As has been made only too plain in the course of history, neither good-will nor sound theology nor faith in God have guarded the priest, any more than a knowledge of physiology and anatomy has guarded the general practitioner in medicine, from the most elementary mistakes in judging and handling his fellow-men. . . ."



**The Human Side of Chess.** By FRED REINFELD. 302 pages, including index. Cloth. Pellegrini & Cudahy. New York. 1952. Price \$3.75.

This book is a collection of brief historical notes on modern chess, with chapters on Anderssen, Morphy, Steinitz, Lasker, Capablanca, Alekhine and Euwe. Fourteen famous games in which they participated are appended.

This book is of interest to all psychiatrists who are chess players; and, perhaps because chess has been called a "screwy game," there seem to be a great many such. The careers which Reinfeld sketches briefly are all of psychiatric interest. The brilliant Morphy was extremely neurotic, if not psychotic in his later days. Steinitz died in a mental institution. Lasker ended his life "in shabby exile." Capablanca's eccentricities were well known. Alekhine's life would repay a full-length psychiatric study.

Reinfeld makes much of the stress which chess imposes on its devotees. The professional chess player, the author seems to think, is under mental stress which may lead to abnormality. He does not seem to consider the contrary possibility that a career as a chess player has a particular appeal for certain types of eccentric, if not neurotic, individuals.

**The Russian Mind.** By STUART RAMSEY TOMPKINS. 289 pages. Cloth. University of Oklahoma Press. Norman, Okla. 1953. Price \$4.00.

The period covered by this book is from the accession of Peter the Great to 1855. There is a very complete coverage of the intellectual movements that affected Russia during this period, and of the governmental policies which regulated the life of the people at that time. The author has used the approach of "social classes" to a great degree, placing emphasis upon the effect on society of a weak middle class. There is no attempt to trace the patterns of Russian family life or in any way to seek for explanations of behavior that cannot be directly traced to broad historical influences. This book will be useful to the student of Russian history, but throws little light on the subject for those interested in the *psychology* of the Russian.

**My Island Home.** By JAMES NORMAN HALL. x and 373 pages. Cloth. Little, Brown and Company. Boston. 1952. Price \$4.00.

James Norman Hall writes an interesting book, and this autobiography proves no exception to the general rule. The statement might also be made, again with this being no exception, that he writes a book designed for light reading only. While there is a great deal of material given about the author's life, practically none of it gives any clue as to his deeper personality make-up. It is unfortunate that Hall died before this book was really completed, as the section dealing with his later life in the South Seas is very sketchy.



**Theoretical Models and Personality Theory.** David Krech and George S. Klein, editors. 142 pages. Cloth. Duke University Press. Durham, N. C. 1952. Price \$2.50.

This symposium is an attempt by workers in psychology and related fields to present their theories of personality with special reference to the construction of these theories and the rules and procedures which the constructors followed. Klein and Krech are concerned with "The Problem of Personality and Its Theory"; Von Bertalanffy with: "Theoretical Models in Biology and Psychology"; Hebb with "The Role of Neurological Ideas in Psychology"; Rapaport with "The Conceptual Model of Psychoanalysis"; Miller with "Comments on Theoretical Models Illustrated by the Development of a Theory of Conflict Behavior"; Eysenck with "The Organization of Personality"; Halsted with "Biological Intelligence"; and Angyal with "A Theoretical Model for Personality Studies."

Presumably the advantage of theory construction is that it enables workers to formulate more meaningful questions about the how, what and why of personality. The contributions are of uneven success in both theory construction and in the formulation of meaningful questions. Perhaps the most provocative paper is by Hebb, who makes a very strong point for "physiologizing" in psychology. The most successful paper, in terms of the goals of this symposium and in terms of the clarity with which it is written, is that by Neal Miller. His excellent discussion of the purpose of theory construction and the procedures involved is made more meaningful by an example of the development and testing of a theory of approach-avoidance conflict behavior.

**The Bride.** By MARGARET H. FREYDBERG. 216 pages. Cloth. Harper. New York. 1952. Price \$2.75.

This is a novel of well-written banalities, centering around the first day of a marriage. The naïve-conventional feelings of the newly-weds and the bride's parents are depicted. Had the book been written 50 years ago, it would have been classified as something new. Published, as it is, in 1952, it is full of accepted rehash, replete with glittering commonplace.

**Readings in Marriage and the Family.** Judson and Mary Landis, editors. 453 pages. Cloth. Prentice-Hall. New York. 1952. Price \$5.65.

Here is a collection of 72 mostly sociological studies written by different authors. The editors define the aim: "This book is designed for use either as a reference source for outside reading, to accompany a textbook in courses in marriage or the family, or as the text or the basic reading for a course, supplemented by lectures and class discussion." It is regrettable that unconscious mechanisms are mostly neglected, although a few timid concessions are occasionally made.



**Child Psychotherapy.** By S. R. SLAVSON. xiii and 332 pages. Cloth. Columbia University Press. New York. 1952. Price \$4.50.

Dr. Slavson's main emphasis is upon the treatment process of the emotionally disturbed child under 12 years of age. He first discusses the various influences and conditions which make for normal personality development including the basic bio-psychological drives and the wider influences of the environment: the physical, material, economic and cultural aspects. The pathology that may occur from deprivation or interference with basic needs or drives or environmental influences is developed in this broad context.

The formulations are largely based on Freudian concepts. However, the author is quick to point out that Freud's major premises were stated from experience with adult patients and in a frame of reference that did not always account adequately for other than the bio-psychological basis of behavior. Actually, Dr. Slavson is eclectic in his thinking and offers recent experimental studies and hypotheses which are more applicable to neo-Freudian child psychology.

Dr. Slavson gives, with enviable clarity, a description of clinical entities, tracing historically the causal factors of maladjustment. This section is excellent and should contribute much toward an understanding of the dynamics that operate in pathology.

The major portion of the book is devoted to a discussion of the actual dynamics of psychotherapy. Here Dr. Slavson has managed to translate heretofore elusively-described aims into a more understandable technique. He states the specific aims of psychotherapy and the dynamic elements of the process, emphasizing the point that there are a variety of therapies and suggesting appropriate types for each clinical entity that is treatable.

This book goes beyond a recapitulation of theoretical constructs. It is a reflection of the most advanced techniques in the field as they are used in actual clinic practice. The book should have wide appeal to anyone concerned with child development.

**How to Overcome Sex Frigidity in Women.** By I. DEVENSKY. 36 pages. William-Frederick Press. New York. 1952. Price, paper \$1.00; cloth, \$2.00.

Under the guise of disseminating modern sexological knowledge, a mass of misinformation is promoted. One could write a whole dissertation on the truly remarkable amount of errors concentrated in these 36 pages. Frigidity is mostly credited to man's faulty technique; a "control technique" for premature ejaculation is recommended consisting of interruption of coitus and—"proper breathing."



**Toward a General Theory of Human Judgment.** By JUSTUS BUCHLER. 176 pages including index. Cloth. Columbia University Press. New York. 1951. Price \$2.75.

Erudite and authoritative though this work may be, it is difficult to comprehend, as many explanations tend to complicate an already complex subject. When the chaff has been threshed from the grain, the theory presented for the development of human judgment is found to be more concise and logical than most, and plausible, if not fully established as sound.

The author's ideas are often tenuous and not altogether new, but they are arranged and presented in an original and refreshingly brief manner, i. e.: "The individual in himself constitutes a community, the reflexive and proceptive community. Logically or genetically, the reflexive community presupposes a social community. The soul converses with itself, as the *Theaetetus* says; but it also articulates itself, wars with itself, consoles itself, and fools itself."

This is not a book to be skimmed, but is interesting and worth while if slowly read and digested.

**Psychanalyse de l'Antisemitisme.** By RODOLPH LOEWENSTEIN. 150 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 500 fr.

This book is known in this country under the title of *Christians and Jews*. Its review here is warranted to bring the reader's attention to an unusually objective study of the problem of anti-Semitism. Dr. Loewenstein is familiar with its irrationality and cruelty. He was born in Russia, migrated to France, and recently has been made aware of anti-Semitism on this continent. He has been subjected to, and has witnessed, its effects on individual personalities. Represented in individual psychology, more or less effectively repressed, the feeling of anti-Semitism is also a phenomenon of collective life.

Psychoanalysts have devoted their efforts to the understanding of the genesis of the apparently incomprehensible symptoms of mental aberrations. Clinical facts initiate the thinking of the observer and, in an attempt at co-ordination, one builds an artificial frame which, for its validation, needs more objective findings. The author is aware of this mechanism and has thus succeeded in writing what should already be considered a classic on the understanding of anti-Semitism.

"The best known and more fruitful cases are those who exhibit a moderate or latent anti-Semitism when the patient requests treatment for a neurosis of some kind. These patients, devoid of any violent anti-Semitism, suddenly develop such symptomatology during analysis. This psycho-



analytic treatment allows an experimental study on anti-Semitism at its beginning" (p. 17). Two conflicts, important in all neuroses, but especially related to the apparition of anti-Semitism, are ambivalence and the Oedipal situation.

From these findings, through the study of the economical, political, and religious factors influencing the evolution of the problem through the centuries, the author concludes that Christians and Jews form a cultural pair. The understanding of anti-Semitism must result from the study of the interrelations between these two groups. This could be viewed as an interdependence with the elaborate reactions to it. The symptom is said to appear when the reactions of one toward the other group gain a sufficient intensity or tend to generalization.

These few remarks cannot do justice to the book. The author has himself given limitations to a full understanding of the problem, as more data are needed. His apparent disbelief in a parallel between ontogenesis and phylogenesis prevents—to a certain extent—more speculations. "It is impossible to eradicate from a civilization the traditional and fundamental elements that historically are the roots of modern anti-Semitism. But it will not be always impossible, we hope, to restrain these potentialities from becoming a real and violent collective anti-Semitism" (p. 141).

The reviewer hopes that every reader of this Quarterly will consult Dr. Loewenstein's book.

**Changing the Attitude of Christian Toward Jew.** By HENRY ENOCH KAGAN. xiii and 155 pages. Cloth. Columbia University Press. New York. 1952. Price \$2.75.

The author, a rabbi, has acted upon the assumption that the basic reason for anti-Semitic reactions among Christians is religious, rather than feeling against an "outside" group. This, he feels, accounts for the *specific* dislike of the Jews, while, at the same time, the possibility of other reasons being mixed in is not discounted. An experiment was conducted where groups of 'teen-agers were first tested regarding the degree of their anti-Jewish attitudes and then given lectures—these lectures being followed by another test. It was found that a lecture on the Book of Psalms and its relation to Jewish culture produced no appreciable change in attitudes. A lecture of this type followed by a personal interview with the rabbi had much more effect. Best results, however, were obtained by a "direct group method" in which the problem of anti-Semitism was brought out directly in the classroom. This allowed an exchange of ideas and at times an emotional catharsis.

The validity of the testing in this book may be questioned by some, as there is some doubt concerning the relationship of answers to basic emotions. There was a follow-up study done, however, which supported the results of the original scores.



**The Wrong Set.** By ANGUS WILSON. 239 pages. Cloth. Morrow. New York. 1950. Price \$3.00.

These short stories seem to accentuate the aloneness of individuals—where one individual is misplaced in the setting he occupies. The atmosphere can be almost macabre at times. While dealing rather deeply with the personalities of his characters, the author does not give the impression that he is actually studying them—there is a certain distance and objectivity about the way the stories are handled. This reviewer liked these stories, while at the same time not believing that they are the best that the author is capable of.

**Witches Three.** By FRITZ LEIBER, JAMES BLISH, and FLETCHER PRATT. 423 pages. Cloth. Twayne. New York. 1952. Price \$3.95.

The one outstanding feature of this book is the introduction, written by John Ciardi. In this, he analyzes the differing concepts of the witch, relating these concepts to our inner needs and drives. The three stories are fairly authentic as to witchcraft lore, but only one of them, "Conjure Wife," by Fritz Leiber, is a first-class piece of writing—the other two being little above the level of the pulp magazines.

**Specific Dyslexia.** By BERTIL HALLGREN. (*Acta Psychiatrica et Neurologica, Supplementum 65*). 287 pages. Paper. Ejnar Munksgaard. Copenhagen. 1950. Price not stated.

This is an exhaustive study of an important educational and intellectual disability, known as "congenital word-blindness." An incomplete definition of this condition would be that it is manifested by poor proficiency in reading and writing in which there is a discrepancy between the low level of attainment here and a higher level in other school subjects, and between the level of attainment and general intelligence.

The author has surveyed the literature (he gives more than 12 pages of references) and he presents a statistical study based on a group of Swedish school children. He concludes that specific dyslexia is relatively common and is probably inherited as a "monohybrid autosomal dominant." His study should be of interest to all concerned with the possible role of inheritance factors as reflected in specific educational disabilities.

**The I. R. A. Coventry Explosion of 1939.** Letitia Fairfield, editor. 284 pages, including appendix. William Hodge and Company, Ltd. London, (British Book Centre. New York). 1953. Price \$3.25.

This book chronicles the trial of the participants in an act which climaxed three-quarters of a century of fanatical patriotism—the bombing at Coventry in 1939 by members of the Irish Republican Army.

This is a clear report of the trial of the five prisoners who were apprehended, and of the conviction of two of them. It is, of course, important psychological as well as historical source material.



**Patterns of Marriage.** By ELIOT SLATER and MOYA WOODSIDE. 299 pages. Cloth. Cassell & Co. London. 1951. Price 17/6 net.

This is a well-meaning and exceeding naïve study of marriage relationship in the urban working classes in England, written by a psychiatrist and a research psychiatric social worker. Two hundred married couples were interviewed in a London hospital during the period of 1943-46. "Half of them had been admitted to wards for neurosis, half to medical and surgical wards. The latter group can be regarded as psychiatrically normal . . ." Thus, starting with a methodological error (Why should the average patient admitted to a medical or surgical ward be free of neurosis?), the authors compare the allegedly healthy with the neurotics, and arrive at conclusions like these: "About one-third of all women said they experienced orgasm always, and another fifth often or enough; one in four said infrequently or insufficiently, and one in 10 had probably never experienced it at all."

Since the typical figures of other investigators range from 90 per cent frigidity, the authors reverse the ratio to 10 per cent. This miracle is simply explained: "There is a significant difference between the women in the Neurotic and the Control groups; the wives of the Neurotics tended on the whole towards the extremes—more of them had a full experience but 15%, as against 5% in the Control group, never experienced orgasm. These figures are not, perhaps, extremely reliable. It was difficult to word the appropriate question, and doubtful sometimes how far there was sufficient self-knowledge of the physiological event. Many who said 'yes' sounded unconvincing, but had to be given the benefit of the doubt [pp.168-9]."

"It was difficult to word the appropriate question"—that means, the difference between vaginal and clitoridian orgasm was not even known to the investigators. Women who "sounded unconvincing . . . had to be given the benefit of the doubt"—that means the conscious or unconscious prevarications of these women were taken at face value.

How poorly the answers of the men were scrutinized is best visible from the fact that not even one of the 200 had been suffering from impotence. "We have no case in the present series [p. 237]." The potency disturbance most frequently encountered in practice—premature ejaculation—is not even mentioned in the index.

**Trends in Psycho-Analysis.** By MARJORIE BRIERLEY. 293 pages. Cloth. Hogarth Press. London. 1951. Price 21 s.

This book is a collection of papers of the British psychoanalyst, published from 1934 to 1947. The book is of mild interest only to those well acquainted with Melanie Klein's theories; the author bases her whole approach on Kleinianism.



**Evolution and Human Destiny.** By FRED KOHLER. 118 pages. Cloth. Philosophical Library. New York. 1952. Price \$2.75.

This is a biochemical-philosophical speculative study, embedded in thermodynamic hypotheses. The author is obsessed with the idea of extropy, under which term he understands the tendency to orderliness, as opposed to entropy, i. e., randomness; even art is subsumed: "Art arose out of man's need to create order in his environment; art is therefore an expression of this need." Despite predicted greater and greater "complexification," neither present-day homo sapiens, nor his alleged successor, member of the "supersocietal organism," is conceded an unconscious. The way to achieve the next step of evolution is thus described:

"Progress toward the culturing of human genetic material outside of the human body and success in fertilizing such cultures and raising human embryos, will make it possible to utilize only the germ cells of a few selected individuals to perpetuate the entire human species. Once this is achieved, the logical necessity of the needs of the integrating organism, will probably force society to adopt this method, despite of the social and moral barriers which at the present would seem nearly unsurmountable. The result of such a societal reproductive system will again greatly increase the rate of societal integration and must within a few generations after its general adoption completely transform the nature of mankind." (pp. 110-111.)

As usual, when a hypothesis runs wild, minor considerations, as human happiness, unconscious needs, etc., are gratuitously overlooked.

**The Inmates.** By JOHN COWPER POWYS. xi and 318 pages. Cloth. Philosophical Library. New York. 1952. Price \$4.50.

This by no means can be taken as a serious novel of life in a small private mental institution. It is difficult to judge whether it is meant as an allegory or as a fantasy, but the distinction is of no great importance. The characterizations are interesting, and at times amusing—amusing in the sense of striking close to home. There are sections of absorbing writing and excellent prose, but, to this reviewer, this does not make the book a good novel. The sense of unity, so necessary to the novel form, is lacking.

**The Letters of Hart Crane.** Edited by Brom Weber. xvi and 426 pages. Cloth. Hermitage. New York. 1952. Price \$5.00.

These letters will prove invaluable to anyone writing a psychological biography of Hart Crane, but in themselves do not constitute a study. They are revealing, as Crane was exceedingly frank in his writing, but there has been no attempt to provide any great amount of background material. These letters, as they stand, are chiefly useful to a student of the literary movement of the 20's.



**Tuberculosis.** By SAUL SOLOMON, M. D. x and 310 pages. Cloth. Coward-McCann. New York. 1952. Price \$3.50.

The usefulness of these "Health Series" books, if this member of the series can be taken as a general indication, will not be confined to the general reader for whom they are designed. Anyone in the fields allied to medicine, even nurses, will find this book valuable, for, while the treatment does not go into the technicalities of the subject, the coverage is very complete.

The newest medical and surgical procedures dealing with tuberculosis are taken up, and an intelligent approach is used to the public health aspects of the problem. The section dealing with the emotional aspects of the disease is rather skimpy, with the emphasis here being placed upon the differences between the impact of tuberculosis upon different individuals, it being held that the reaction upon the individual is a stress reaction, not a specific reaction to one disease.

**The Conformist.** By ALBERTO MORAVIA. 376 pages. Cloth. Farrar, Straus and Young. New York. 1951. Price \$3.50.

The novels of the recent Italian writers have tended to be highly "realistic" and more often than not morbid in character. Moravia is no exception to this. This is a trend that is not objected to by this reviewer, except when this "case study" type of approach works to the detriment of the book as a novel—as happens in *The Conformist*. The subject of this novel is a Fascist official who is influenced in everything he does by a strong desire to conform—to be a "usual" person and follow the crowd. He submerges his own individuality to the general pattern. An early traumatic homosexual experience is brought out. The realization by the conscious mind of these thoughts strains credulity, as Moravia gives his "hero" almost complete insight into the unconscious forces that guide him. This book is not up to the standards of some of the author's earlier work.

**Thinking.** By GEORGE HUMPHREY. 331 pages. Cloth. New York. 1952. Price \$4.50.

"In general," the author states, "the book is intended to give a critical treatment of experimental work that has already been done." It presents theory as it has developed out of experiments and reviews experimentation in the hope that more may be done.

The author has presented a systematic analysis of experimental work on the "thought processes," including chapters on association; on the work of the Wurzburg group; the mechanism of thinking; the work of Selz; the Gestalt theory of thought; thought and motor reactions; language and thought; generalizations; and an excellent chapter dealing with summaries and conclusions.

This text is a wealth of information for the philosopher and psychologist.



**The Devils of Loudun.** By ALDOUS HUXLEY. 340 pages. Cloth. Harper. New York. 1952. Price \$4.00.

It is difficult in this book to tell exactly where objective history leaves off and the author's own ideas begin. As far as this reviewer could determine the basic facts presented are historically accurate, but it was manifestly impossible to check any great number of the references used.

Urbain Grandier, when vicar of Loudun, was accused of bewitching 17 Ursuline nuns, and, after a trial where there was little attempt at justice, was burned at the stake. The author takes the view that Grandier was innocent of the charges, and that there was no true "devil possession" in the case. He ascribes the actions of the nuns to mass hysteria brought about, in part, by sexual frustration. While making these statements, Huxley in no way shows himself to be anti-religious, and in part the book becomes almost a philosophical treatise. The conclusions drawn are psychologically sound—though there might be skepticism regarding some of the historical assumptions.

**The Moral Theory of Behavior.** A New Answer to the Enigma of Mental Illness. By FRANK R. BARTA, M. D. 27 pages. Fabrikoid. Thomas. Springfield, Ill. 1952. Price \$2.00.

It is unfortunate that psychiatrists cannot get together and decide on a correct explanation of the cause and effect of mental illness. There are almost as many theories as there are psychiatrists (or psychologists, for that matter). Dr. Barta's view is derived from many theories. He has built up his own combination of ideas which, for him, explains the dynamics of mental-problem development. He tells the reader that he is successful in his therapy, but he does not disclose his method of treatment. Further, he does not develop, too well, his ideas of a "moral theory of behavior."

However, the booklet contains several interesting figures based upon his classification and his dynamics of mental illness according to four groups of personalities: those who expect too much of others; those who expect too little of others; those who expect too much of themselves; and those who expect too little of themselves.

Dr. Barta's ideas have merit but he does not explain them clearly.

**Tara's Healing.** By JANICE HOLT GILES. 253 pages. Westminster Press. Philadelphia. 1951. Price \$3.00.

*Tara's Healing* is a naïvely described emotional rescue of a neurotic physician through loving contact with simple farmers in Kentucky. Mildly interesting is a side-show: A religious sect is described, and their preacher depicted. The conversion of this preacher, his sincerity and truthfulness, are more true to life than the nebulous official hero of the book.



**The Postural Development of Infant Chimpanzees.** By A

RIESEN and ELAINE F. KINDER. 204 pages, including index. Cloth. Yale University Press. New Haven. 1952. Price \$5.00.

Professor Riesen and Dr. Kinder have engaged in a basic study of the postural development of the infant chimpanzee with reference to the monkey as well as to ape and man. The treatment of the study of the postural development of the infant chimpanzee with reference to the monkey as well as to ape and man. The treatment of the study of the postural development of the infant chimpanzee with reference to the monkey as well as to ape and man.

The subjects of the present study were separated from their mothers very early at the Yerkes Laboratories of Primate Biology and isolated in an experimental nursery where their development was studied under controlled conditions. The conditions of rearing are stated precisely. The examination of the health material is described in detail and there are notes on the comparative aspects of these nursery chimpanzees with chimpanzees raised in human families. The book is far too technical for general use, but promises to be a basic book for the psychological study of infancy.

**The Snow Was Black.** By GEORGES SIMENON. Translated from the French by Louise Verèse. 246 pages. Cloth. Prentice-Hall. New York. 1950. Price \$2.75.

Monsieur Simenon, the Belgium-born novelist who now makes his home in California, has become known for what his publishers call "psychological" novels, several of which have already been successfully made into movies. By professionals and semi-professionals his novels will more adequately be described as mystery novels of a deeply stirring kind.

*The Snow Was Black* is a somber description of a young man's egotism and his almost unbelievable degradation, which leaves out no realistic detail, a matter we are used to with regard to Mr. Simenon's novels. Frank, whose life we follow through black market activities and the brothel run by his mother, finally kills an aged benefactress of his childhood. He betrays the girl who loves him sincerely. Destiny in the end catches up with him.

**Personality and Sex Conflicts.** By H. H. HUSTED. 265 pages. Cloth. McBride. New York. 1952. Price \$3.95.

This is a naïve-popular sermonoid with good intentions and rather confused execution. The author takes a dim view of the postwar generation ("New Barbarians") and recommends teaching the Golden Rule.

**It's Different for a Woman.** By MARY JANE WARD. 246 pages. Cloth. Random House. New York. 1952. Price \$3.00.

The author of *The Snake Pit* presents a weak and mild satire of Suburbia. The switch from attack to mild satire does not come off; the book is not exactly boring, but is insignificant.



**The Devil Boy Came Back.** By CHARLES H. KNICKERBOCKER. 249 pages. New York: A. A. Wyn, Inc. New York. 1951. Price \$2.75.

It is difficult to say the psychology of this book can be summed up with the observation that off and the knowledge is dangerous. The author seems to assume that every person is a mixture of *perverse* masochistic-sadistic traits and defenses. He festly im- poses the universality of *psychic* masochism with *perversion* masochism, Urbair builds his *dramatis personae* on this misunderstanding. As he has Ursuline, with an erroneous assumption, the resultant errors are unavoidable. was bur- on the surface, he describes the return of a psychopathic young soldier to innoce- little Maine home town; the suspicion of the conservative inhabitants; the e- and their reactions to the boy's wife, an ex-prostitute from Chicago. Be- abou- hind this, the author depicts, rather maliciously, the neuroses of the country ley doctor, the country lawyer, and the country editor. Were the author not confused on basic psychiatric topics, he would be a man to watch for future literary achievements; sometimes he manages to build a scene of real value.

**Age Is No Barrier.** 1952 Report of the New York State Joint Legislative Committee on Problems of the Aging. 171 pages, including index. Paper. Free, upon request to Hon. Thomas C. Desmond, 94 Broadway, Newburgh, N. Y.

This report includes a survey of the general and—as applied to New York State—particular situation brought about by our aging population. It covers psychological as well as physical problems, social as well as economic. There are chapters on the re-designing of jobs for older persons and the rehabilitation of the physically handicapped older person. Dr. Ernest M. Gruenberg of the State Mental Health Commission contributes a discussion which relates the problem of mental disorder to the problem of aging.

The report is handsomely printed and is well indexed. It should be useful to many individuals, as well as to social and community agencies. Although it does not seem to have been intended for that specific purpose, it is a fine contribution to mental hygiene.

**Insanity Laws.** By WILLIAM R. DITTMAR. 96 pages. Paper. Oceana. New York. 1952. Price \$1.00.

This is a very brief coverage of the insanity laws of the 48 states. The information provided will prove helpful in supplying general information on the subject, but covers no more than the main points. The psychiatric definitions given are much too brief and in certain cases are inaccurate.



**Head Against the Wall.** By HERVÉ BAZIN. 255 pages. Cloth. Prentice-Hall. New York. 1952. Price \$3.95.

When an author has had some success in writing of mental conflicts there seems to be a strong urge to carry this one step further and bring in actual psychiatric background. This, of course, requires far more specialized knowledge. Bazin's first novel, *Viper in the Fist*, was a well worked out study of a neurotic woman—this later effort falls short of the standards set in the first work. Lack of knowledge of the basic facts of psychiatry is shown—both as regards mental processes and treatments. For example: Insulin therapy, shock therapy, and prefrontal lobotomy are all mentioned as being used before they were actually put into practice. The theme—the man doomed to spend his life in mental institutions because of personality weakness rather than any true mental disease, with the usual sidelights of sadistic institution directors, etc.—is not new, and the handling of it is not one to make the book in any way exceptional.

**The Nature of Nondirective Group Psychotherapy.** An Experimental Investigation. By LEON GORLOW, Ph.D., ERASMUS L. HOCH, Ph.D., and EARL F. TELSCHOW, Ed. D. viii and 143 pages. Cloth. Bureau of Publications, Teachers College, Columbia University. New York. 1952. Price \$3.25.

This book should be of particular interest to those concerned with the research possibilities of group psychotherapy. Gorlow, Hoch and Telschow have examined the process of nondirective group psychotherapy from three points of view: (1) an analysis of the leader's behavior and its correlates; (2) the behavior of members as therapists for one another; and (3) the nature of the group process in terms of certain specific variables. The investigators developed a method for the quantification of the transcribed therapy protocols. They clinically evaluated the initial personal adjustment of the members and made estimates as to the least and most benefited members of the group. They related gain to behavior in group sessions. The Rorschach, an incomplete sentence test, and a self-rating check list, administered pre- and post-therapy, were used to provide independent measures of the subjects' initial personal adjustment, etc.

In view of the small number of subjects (117 subjects divided into three groups) and the reliance primarily upon verbal data, the authors regard their findings, not as definitive, but as suggestive of hypotheses for future research. There is a bibliography of 101 titles. The five appendices include the definitions and examples of categories of analysis, the incomplete sentence test, self-rating check list, a group analysis sheet, and group leader feelings toward the members.



**Psychological Studies of Human Development.** Raymond G. Kuhlen and George G. Thompson, editors. 521 pages. Paper. Appleton-Century-Crofts. New York. 1952. Price \$3.50.

The editors, in the foreword of this text, state the purpose and methodology clearly and concisely: "This book is concerned with the psychological aspects of human growth and development, with those psychological changes that occur with increasing age and with the many conditions that influence the course of human development and behavior. . . . This book is not a systematic integration of the literature on developmental psychology. Rather it is a series of seventy-one papers, mainly research reports, adapted and abridged from scientific journals."

The 71 papers are divided into 13 broad areas of psychological endeavor. The first nine are under the collective title "Physical Factors in Psychological Development." There are five in each of the following sections: "Processes of Learning and Adjustment," "Psychological Growth Under Different Social Cultural Conditions," "Intellectual Changes with Age," "Intelligence and Psychological Adjustment," "Patterns of Language-Conceptual Growth," "Interest Patterns and Their Implications," "Social Development: Interpersonal Relations," "Adjustment in School," "Vocational Orientation and Adjustment," and "Some Factors in Personal and Emotional Adjustment." "Growth of Social Values and Attitudes" and "Home Family Relations" each have six articles.

These papers naturally vary in significance and reliability as well as in interest to varying readers. However, as a group, they represent some of the better studies in the areas covered. Rather prominent workers in the field, such as Louis M. Terman, Arnold Gesell, H. E. Garrett, Kurt Lewin and many others have papers included in this book of readings. The abridgements have not been detrimental in those that the reviewer has been able to compare with the originals. This text should prove to be a most valuable source book on current research and psychology, and should be useful to both the beginning student and the esoteric follower of the field.

The reviewer considers it a valuable addition to his library and his only lament is that it is not of a more durable binding.

**In the House of the King.** By LOUIS ZARA. 306 pages. Cloth. Crown. New York. 1952. Price \$3.00.

In this historical novel the author portrays Philip II of Spain as being perpetually haunted by intense guilt feelings due to an unresolved Oedipus complex; and, by means of dream sequences, he keeps this idea before the reader. Philip is held to be a far nicer and less unyielding person than the histories portray. Both as regards the psychiatric overtones and the novel as a novel, the verdict is a polite yawn—not bad enough to be really condemned and not good enough to be praised.



**A Behavior System.** An Introduction to Behavior Theory Concerning the Individual Organism. By CLARK L. HULL. viii and 372 pages. Cloth. Yale University Press. New Haven. 1952. Price \$6.00.

Clark Hull's *A Behavior System*, published posthumously, is the second and last in a proposed series of three books designed to investigate what he has called "ordinary mammalian behavior." In this volume, he has attempted to apply the behavior principles set forth in *Principles of Behavior* (1943) and revised in *Essentials of Behavior* (1951) to the non-social behavior of both animals and humans. He has developed a list of 17 postulates and their corollaries, based chiefly on the behavior of the rat. From these postulates and corollaries, have been deduced over 130 theorems dealing with different aspects of non-social behavior. This book is primarily concerned with the deduction of these theorems and the agreement or disagreement between them and empirical findings, when such exist.

Hull's behavior system, which may be classified as a reinforcement theory of learning, may strike many as an over-ambitious as well as premature attempt at "pseudo-quantification" of behavior. Others may disagree with it because of his assumption that the same primary laws apply to the behavior of all mammals. They may feel that laws based on rats cannot be applied—without more intensive experimentation—to humans.

The book is not easy reading, especially for those unversed in Hullian terminology. However, Hull's behavior system has had considerable influence on current psychological work. Attempts have been made to apply his theory to social learning. This book, therefore, merits serious consideration by all those interested in the systematic investigation of behavior.

**Principles of Human Relations.** Applications to Management. By NORMAN R. F. MAIER. 456 pages. Cloth. Wiley. New York. 1952. Price \$6.00.

A book of this type is most important during times of stress when management has employee morale problems which are affected by increasing labor turnover and by union leadership. Loyalty to management is, at present, very unstable. For this reason, public relations departments are extremely important, and this book is timely because it concerns itself with methods and principles of human relations in industry. To Professor Maier these methods and principles are not just theory. He has actually experimented with them in several existing industrial organizations. He considers that his ideas are "advanced and progressive."

Dr. Maier's emphasis is on group organization and group discussion to minimize the impression of forcing new ideas or plans and to minimize the hostility or the apathy which often appears. He offers methods of public or human relations for all grades of executives from the foreman to the top administrator. And to reinforce his ideas, the author illustrates his points by giving case histories of problem situations.



## CONTRIBUTORS TO THIS ISSUE

ERIC BERNE, M. D. Eric Berne is in private practice in Carmel and San Francisco, Calif. He is a diplomate of the American Board of Psychiatry and Neurology and a fellow of the American Psychiatric Association; consultant in neurology and psychiatry for the United States Army; attending psychiatrist, Veterans Administration Mental Hygiene Clinic, San Francisco; assistant psychiatrist, Mount Zion Hospital, San Francisco; and consulting psychiatrist, Carmel Unified School District, Carmel, Calif. He studied at McGill University, the Yale Institute of Human Relations, and the New York and San Francisco Psychoanalytic Institutes. Because of his interest in comparative psychiatry, he was recently elected a corresponding member of the Indian Psychiatric Society.

He is the author of *The Mind in Action*, a layman's guide to psychiatry and psychoanalysis (1947), which was also published in England and has been translated into Swedish and Italian. He is the author of many articles on psychiatric and neurological subjects. His publications in this QUARTERLY include "The Nature of Intuition" (1949) and "Cultural Aspects of a Multiple Murder" (1950).

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RAYMOND R. SACKLER, M. D. Dr. Raymond R. Sackler is associate director of the Creedmoor Institute for Psychobiologic Studies and is a senior psychiatrist at Creedmoor (N. Y.) State Hospital. He has been on the medical and research staff at Creedmoor since 1945, is an editor of the *Journal of Clinical and Experimental Psychopathology*, and is author or co-author of many scientific articles dealing with endocrinology and psychiatry.

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ARTHUR M. SACKLER, M. D. Dr. Arthur M. Sackler is director of research at Creedmoor (N. Y.) State Hospital and is author or co-author of a number of scientific articles on the subjects of endocrinology and psychiatry. He is director of the Creedmoor Institute for Psychobiologic Studies. Dr. Sackler has been a member of the Creedmoor hospital staff since 1944 and director of research there since 1949. He is editor-in-chief of the *Journal of Clinical and Experimental Psychopathology*.

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MORTIMER D. SACKLER, M. D. Mortimer D. Sackler, M. D., is a senior psychiatrist at Creedmoor (N. Y.) State Hospital and is an associate director of the Creedmoor Institute for Psychobiologic Studies. He is an editor of the *Journal of Clinical and Experimental Psychopathology* and is author or co-author of a number of scientific articles.



JOHAN H. W. VAN OPHUIJSEN, M. D. The late Dr. van Ophuijsen, listed as a consultant in the authorship of "A Three-Year Follow-up Study of Nonconvulsive Histamine Biochemotherapy, Electric Convulsive Post-Histamine Therapy, and Electric Convulsive Therapy Controls," was director of the Creedmoor (N. Y.) Institute for Psychobiologic Studies at the time of his death in 1950. A Netherlander by birth, he had been in psychoanalytic and psychiatric practice in New York City for 15 years; and he was internationally known as a leading figure in psychoanalytic circles. He was a consultant and member of the Creedmoor research group at the time the studies reported in the present *QUARTERLY* article were begun.

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MONTAGUE ULLMAN, M. D. Dr. Ullman received his medical degree in 1938 from the New York University College of Medicine. He served a two-year rotating internship at Morrisania City Hospital in New York City. Residency training included a year in neurology at Montefiore Hospital and a year at the New York State Psychiatric Institute. During World War II he served as neuropsychiatrist with the armed forces in this country and abroad.

Dr. Ullman completed the comprehensive course in psychoanalysis at the New York Medical College in 1948 and has since been engaged in the private practice of psychoanalysis in New York City. He is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, and an associate psychiatrist in the department of psychiatry at the New York Medical College.

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JAMES H. WALL, M. D. Dr. Wall has been associated with the New York Hospital—Westchester Division since August 1, 1928, and has been medical director there since July 1, 1946. He is associate professor of clinical psychiatry at Cornell University Medical College.

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JACK GREEN, M. D. Dr. Green is at present senior physician at the State Hospital for Mental Disease, Howard, R. I. Born April 16, 1923 in Poland, his early upbringing and education were in Montreal, Canada. He received his B. Sc. degree from McGill University in 1943, and his M. D., C. M. degrees from McGill University Medical School in 1947. He began psychiatric training at Queen Mary Veterans Hospital, Montreal in 1948.

Dr. Green came to the United States in 1949 as a resident in psychiatry at the State Hospital for Mental Disease at Howard. He had a personal psychoanalysis from 1949 to 1951 at Boston.



**PHILLIP POLATIN, M. D.** Dr. Polatin is a graduate of the College of Physicians and Surgeons, Columbia University, and has been in psychiatry for 20 years. He is now chief of the female service of the New York State Psychiatric Institute, New York City; assistant clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University; and a practising psychiatrist and psychoanalyst. His primary interests are teaching and research. He has written extensively for psychiatric journals, lectured to lay groups, and is well known as a therapist and teacher.

Dr. Polatin and the novelist, Ellen C. Philtine, were married some 25 years ago while both were still students, Dr. Polatin just starting at medical school. They have written two books together: *How Psychiatry Helps* (Harper), and *The Well-Adjusted Personality* (Lippincott). They have one son, Peter, aged 10, who attends the Riverdale Country School.

Dr. Polatin belongs to numerous psychiatric and medical associations, including the American Psychiatric Association, the American Psychoanalytic Association, the American Psychosomatic Association and the American College of Physicians. He is a member of the New York Academy of Medicine, a diplomate of the American Board of Psychiatry and Neurology and, for several years has been an assistant examiner for that board.

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**ABRAHAM S. EFFRON, M. D.** A graduate of the Medical College of Queens University of Belfast, Ireland, Dr. Effron is now clinical assistant in psychiatry at the New York University-Bellevue Hospital Medical Center, New York City. He is also associate in neuropsychiatry at Barnert Memorial Hospital, Paterson, N. J., and assistant in psychiatry at University Hospital, New York City.

Following an internship at the Hospital for Joint Diseases, New York City, Dr. Effron had served residencies in neurology and psychiatry at Bellevue Hospital and at the New York State Psychiatric Institute, New York City. He is a frequent contributor to the medical literature.

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**RICHARD C. ROBERTIELLO, M. D.** Dr. Robertiello is a graduate of Harvard University and of the College of Physicians and Surgeons, Columbia University (1946). He interned at Morrisania City Hospital in New York City, had a six-month residency in psychiatry at Central Islip (N. Y.) State Hospital, and served two years in the army as a neuropsychiatrist stationed at Fort Knox, Ky. He then served residencies at the New York State Psychiatric Institute and at Bellevue Hospital, New York City.

Dr. Robertiello is now in private practice in New York City and is attending the psychoanalytic course at New York Medical College. His particular interests at present are psychoanalysis and child psychiatry. Dr.



Robertiello is a member of the American Psychiatric Association, the Society of Medical Psychoanalysts and other professional bodies. He is 29 years old, is married and has two children.

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**BEN KARPMAN, M. D.** Dr. Karpman is chief psychotherapist at St. Elizabeths Hospital, Washington, D. C. He is an internationally known writer and lecturer on psychopathological and psychoanalytic subjects. Graduated in medicine from the University of Minnesota in 1919, Dr. Karpman had analytic training in Vienna in 1923 and 1924 and again in 1926 and 1927. His books include *Case Studies of the Psychopathology of Crime* (4 vols.), *The Individual Criminal*, *The Alcoholic Woman*, and *Objective Psychotherapy*. He has a total of more than 90 published studies and has contributed previously to this *QUARTERLY*.

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**IRVING S. COOPER, M. D., Ph.D.** Dr. Cooper is an attending neurosurgeon at Central Islip (N. Y.) State Hospital. He is a graduate of George Washington University, from which he received his M. D. (with distinction) in 1945; and he holds a Ph.D. in neurosurgery from the University of Minnesota. Following his medical school graduation, Dr. Cooper served a rotating internship at the United States Naval Hospital at St. Albans, N. Y., served for 12 months in general surgery and 12 months in neurology and neurological surgery in the United States Navy, then held a fellowship in neurology and neurological surgery at the Mayo Clinic and Foundation from April 1948 to April 1951.

He became assistant professor of neurosurgery, New York University Post Graduate School of Medicine in April 1951. He is associate attending neurosurgeon for University and Bellevue Hospitals, for the Hospital for Special Surgery and for St. Joseph's Hospital, and is attending neurosurgeon for Roslyn Park Hospital—all in New York City or the metropolitan area. Dr. Cooper is a member of the American Medical Association, the American Federation for Clinical Research and other professional organizations. He is a diplomate of the National Board of Medical Examiners and a diplomate in neurology of the American Board of Psychiatry and Neurology, for which he is an assistant examiner.



## NEWS AND COMMENT

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### FIFTH WORLD MENTAL HEALTH CONGRESS IN TORONTO

The World Federation for Mental Health announces that the Fifth International Congress on Mental Health will be conducted in Toronto, from August 14 to 24, 1954. The previous congresses were in Washington, Paris, London and Mexico City; and the world federation developed from the third in London in 1948. It has a membership of 72 mental health and professional societies in 38 countries and has consultative status with UNESCO and the World Health Organization.

The theme of the fifth congress will be "Mental Health in Public Affairs"; and it will be held at the University of Toronto.

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### HENRY ALDEN BUNKER, M. D., DIES IN NEW YORK AT 63

Dr. Henry Alden Bunker, formerly with the New York State Department of Mental Hygiene and a practitioner of psychiatry and psychoanalysis in New York City for many years, died at his home there on March 19, 1953 after a long illness. He was 63 years old. Dr. Bunker was assistant director of the New York State Psychiatric Institute from 1921 to 1926 when it was still on Ward's Island. He resigned in the latter year to enter private psychoanalytic practice.

Dr. Bunker had been an associate editor of the *Psychoanalytic Quarterly* since 1933; he was author of a number of psychoanalytic articles and was a translator of Freud; he was president of the New York Psychoanalytic Society, 1948-50. Born in Brooklyn and a graduate of Harvard Medical School in 1915, Dr. Bunker had served a psychiatric internship in Boston before joining the army medical corps in World War I and doing psychiatric work overseas. He was in practice in Massachusetts for two years following the war, then joined the staff of the Psychiatric Institute. Dr. Bunker leaves his widow, three daughters and a son, all of New York City.

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### COHEN NAMED CLINICAL DIRECTOR OF HEALTH INSTITUTE

Dr. Robert A. Cohen has been appointed clinical director of the National Institute of Mental Health, it has been announced by Dr. Leonard A. Scheele, surgeon-general of the United States Public Health Service. Dr. Cohen goes to the public health service from Chestnut Lodge, Rockville, Md., where he has been clinical director since 1948. He will be in charge, for the National Institute of Mental Health, of a program of clinical research into mental diseases and psychotherapy which is to be conducted in the clinical center that is nearly completed in Bethesda, Md.



## YALE RECEIVES GRANT FOR PSYCHIATRIC RESEARCH

A grant of \$6,000,000 to Yale University by the Social Research Foundation has been announced—the purpose being “to support research into why people become mentally and emotionally ill, why they get well, how best to help them get well and how best to help them from becoming mentally and emotionally ill.” The foundation announces that distribution of this fund will not be confined to Yale and that it is planned to spend both income and principal in about twenty years.

A board of directors of scientists, not more than two of which may be from a single institution, is to administer the fund. The present directors, named by the Yale Corporation, are: Frederick C. Redlich, M. D., and Vernon W. Lippard, M. D., Yale University School of Medicine; Charles D. Aring, M. D., Cincinnati College of Medicine; John D. Benjamin, M. D., University of Colorado; David Shakow, Ph.D., University of Illinois College of Medicine; George W. Thorn, M. D., Harvard Medical School; and John C. Whitehorn, M. D., the Johns Hopkins University. Dr. Redlich, who is professor of psychiatry at Yale, is chairman.

The board held its first meeting in New Haven, March 27 and 28, 1953. Dr. Sibylle Escalona, research psychologist in the Yale Child Study Center, was appointed executive officer. The foundation has a temporary address at 333 Cedar Street, New Haven 11, Conn. The board has issued an invitation for communications of ideas but announces that it will not be ready to make decisions on grants for at least six months.

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## DR. MERRIMAN, FORMER HOSPITAL HEAD, DIES AT 77

Willis E. Merriman, M. D., former head of Utica and Manhattan (N. Y.) State Hospitals, who retired as director of the Utica hospital in 1946, died at his home in Utica on February 14, 1953 at the age of 77. Dr. Merriman, born in Albany, N. Y., and a graduate of the Albany Medical College in 1902, had spent most of his professional career in the service of New York State, first as an assistant physician at the New York State Hospital for Incipient Pulmonary Tuberculosis, but principally in the hospitals of the Department of Mental Hygiene. He became superintendent of Manhattan State Hospital in 1933, and, in 1939, was transferred to head the Utica institution.

Dr. Merriman was a life fellow of the American Psychiatric Association and a member of numerous professional and other societies. In his earlier years, he was author or co-author of a number of scientific papers, including publications in this *QUARTERLY*. Dr. Merriman had lived in Utica since his retirement. He leaves his widow, the former Lena May Eggers Saunders, to whom he was married in 1943, and a brother.



**MURIEL IVIMAY, M. D., PSYCHOANALYST, DIES AGED 64**

Dr. Muriel Ivimay, one of the founders with Karen Horney of the American Institute for Psychoanalysis and formerly its associate dean, died following a coronary occlusion in New York Hospital on February 26, 1953. She was 64 years old. Born in London and brought to this country as a small child, Dr. Ivimay was graduated from the Johns Hopkins Medical School in 1922, and following a two-year internship at the Henry Phipps Psychiatric Clinic, the Johns Hopkins Hospital, had been in the practice of psychiatry and psychoanalysis ever since. In the course of her long professional career, she had served on the staffs of the outpatient department of the Phipps Psychiatric Clinic, the old Cornell Clinic, the outpatient department of the New York Infirmary for Women and Children, the Vanderbilt Clinic, the outpatient department of the New York Neurological Institute, and the outpatient department of the Payne Whitney Psychiatric Clinic of New York Hospital.

In the medical education field, Dr. Ivimay had taught psychiatry, neurology and psychoanalysis at the Henry Phipps Clinic, the New York University Medical College, the Payne Whitney Psychiatric Clinic, the New School for Social Research, and the American Institute for Psychoanalysis, where she was training analyst and instructor at the time of her death. She had conducted clinics for a number of social agencies.

Dr. Ivimay was the author of a number of scientific articles on psychoanalysis, neurology and other medical topics. She was a member of the American Psychiatric Association, the Association for the Advancement of Psychoanalysis, the New York Neurological Society and other professional organizations. She is survived by two sisters and a brother.

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—o—**DR. HENRY NAMED HEAD OF FRIENDS AND FAMILIES GROUP**

George W. Henry, M. D., associate professor at Cornell University Medical College and attending psychiatrist at New York Hospital has been elected president of the American Association of Friends and Families of Psychiatric Patients. Other new officers are: Edward M. Shepard, M. D., of the Cornell Medical College faculty and the Payne Whitney Psychiatric Clinic, vice-president; Maurice J. Shore, Ph.D., director of Saint Edwards Consultation Clinic, executive vice-president; and Howard M. Newburger, Ph.D., secretary-treasurer. The association aims to aid both patients and their families in such problems as advice on individual treatment, arrangements for hospitalization, care of patients' estates, readjustment of convalescent and paroled patients, and other matters consequent on mental illness.



### DATA SOUGHT IN STUDY OF ENDOCRINE DISORDERS

Material on cases where endocrine disorders, particularly hyperthyroidism and hypoglycemia, may be implicated in crime is being sought by Wladimir Eliasberg, M. D., of 151 Central Park West, New York 23, N. Y.; and he has asked this *QUARTERLY* to inform its readers that he would welcome any pertinent data. He has been circulating a questionnaire among lawyers, designed to determine for computation purposes, some idea of the prevalence of cases in which either the attorneys themselves or medical experts believed there might be a relationship between endocrine disturbance and crime. He is interested in percentages of such cases, in reliability of diagnoses, and in the legal disposition of cases where irresponsibility on the basis of hypoglycemia or thyroid toxicity was pleaded as defense. He is also interested in other details, including characteristic case histories; and he has asked *THE QUARTERLY* to say he would be glad to have any pertinent information from medical sources.

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### AMERICAN ORTHOPSYCHIATRIC ASSOCIATION REORGANIZED

The reorganization of the American Orthopsychiatric Association, to further its program of co-operation by psychiatrists, social workers and psychologists in the study and treatment of mental and emotional disorder, has been announced by the association's president, Morris Krugman, Ph.D., of Brooklyn, psychologist and assistant superintendent of schools for the New York City Board of Education. Dr. Krugman announced that Marion Langer, Ph.D., of New York City, social welfare administrator and college teacher of sociology and social work, had been named executive secretary of the association. The association plans, Dr. Krugman says, to promote further regional organizations in various parts of the country and to work more closely with other professional organizations which share its interests. Hyman S. Lippman, M. D., of St. Paul, Minn., is to succeed Dr. Krugman as president for the coming year.

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### CHILD PSYCHIATRY ACADEMY IS ORGANIZED

A new national medical society to be known as the American Academy of Child Psychiatry was founded in Cleveland in February with a membership of about a hundred specialists. George E. Gardner, M. D., of Boston, was chosen president; Fred Allen, M. D., of Philadelphia, president-elect; Frank J. Curran, M. D., of Charlottesville, Va., secretary, and Mabel Ross, M. D., New York City, treasurer. The academy announces that membership is limited to members of the American Psychiatric Association with at least two years of training in child psychiatry in an adequate clinic setting and at least five years of experience in child psychiatry following the training period. A member's chief professional interest and activity must also be in the field of child psychiatry.



## STRESS RESEARCH REPRINTS ARE SOUGHT BY HANS SELYE

Hans Selye, M. D., and his co-worker, Alexander Horava, M. D., of the Institute of Experimental Medicine and Surgery, Université de Montréal, Montreal, Canada, have asked THE PSYCHIATRIC QUARTERLY to call the attention of its readers to their need for reprints of scientific articles "pertaining to research on 'stress' and the so-called 'adaptive hormones' (ACTH, STH, corticoids, adrenergic substances, etc.)."

The institute of which Dr. Selye is director commenced in 1950 the publication of a series of reference volumes, *Annual Reports on Stress*, in which it is endeavored to survey the entire current world literature, usually, say the compilers, between 2,000 and 4,000 publications. The material for the *Annual Reports* has been compiled directly from publications, from monographs, from abstract journals and from reprints sent to the institute by the authors themselves. Drs. Selye and Horava say such reprints are the best sources and report that they have sent out individual requests to several thousand authors engaged in stress research to submit their reprints. Noting that even this procedure failed to give the coverage desired because of failure to reach some authors and failure to receive reprints from others promptly, the Montreal scientists are now requesting medical journals to ask any readers publishing material on stress to send reprints to the Institute of Experimental Medicine and Surgery as soon as reprints are available.



## "HAND-TALKING" CHART DEVELOPED FOR APHASICS

Hamilton Cameron, M. D., 601 West 110th Street, New York 25, N. Y., has asked THE QUARTERLY to call attention to a "hand-talking" chart he devised for one-hand use when he himself was in a state of right hemiplegia and "complete" aphasia following coronary thrombosis and cerebral embolism. This chart contains 20 signs, made by one hand and covering simple communication needs and some of the requests most likely to be made by the patient. The alphabet and numerals are appended to the chart for the use of a patient who is able to read and able to point with a pencil to spell out further communications. Dr. Cameron states that he visualized the chart while he was completely helpless during the first four weeks of his illness, but that it was two and one-half years before he was able to communicate his ideas orally to an artist who made the drawings. He considers the chart part of a rehabilitation process which ended in apparent complete physical recovery only after six years.

Dr. Cameron's chart and reports of its development and use have appeared in the *Medical Times* and *Arizona Medicine*, and the *New England Journal of Medicine* devoted an editorial to it. The chart is available to physicians on application to Dr. Cameron.



**BEATRICE HINKLE, M. D., PSYCHOANALYST, IS DEAD AT 78**

Dr. Beatrice M. Hinkle, New York City psychiatrist and psychoanalyst since 1905, died at the age of 78 in New York City on February 28, 1953 after a short illness. A graduate of Cooper Medical College (now the medical department of Stanford University) in 1899, Dr. Hinkle was city physician of San Francisco from 1899 to 1905, one of the earliest instances of a woman holding such a public health post.

Dr. Hinkle founded what is said to have been the first psychotherapeutic clinic in the United States at Cornell Medical College in 1908. She was the author of numerous scientific articles and a book, *The Recreating of the Individual*, and she was translator of C. G. Jung's *The Psychology of the Unconscious*. She was a member of the American Psychiatric Association and other professional groups.

Dr. Hinkle was married in 1892 to Walter Scott Hinkle, San Francisco attorney, who died in 1899. She leaves a son, a daughter and four grandchildren.

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**PSYCHIATRIC NURSING DISCUSSION TO OPEN CONVENTION**

The newly-formed interdivisional council on psychiatric and mental health nursing of the National League for Nursing will meet on Monday, June 22, 1953, in Cleveland, the first day of the league's first convention, which will be conducted from June 22 through June 26. Officers will be introduced, and the purposes of the interdivisional council will be discussed. Dr. Bernard H. Hall, clinical psychiatrist of the Menninger Foundation, will speak in the evening on, "A Colleague Looks at Psychiatric Nursing," and a general discussion of trends and needs in psychiatric nursing will follow.

Other special sessions, as well as general meetings of wider interest will be conducted during the convention week. Additional information can be obtained by writing to the league headquarters, 2 Park Avenue, New York 16, N. Y.

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**GILBERT M. BECK, M. D., OF BUFFALO MEDICAL SCHOOL, DIES**

Gilbert M. Beck, M. D., psychiatrist and neurologist, and psychiatrist-in-chief at the University of Buffalo Medical School, where he had been a faculty member for 24 years, died in Buffalo on January 9, 1953 at the age of 53. Dr. Beck received his medical degree from the University of Buffalo in 1923, completed an internship and residency, became an assistant in neuroanatomy and psychiatry at the Johns Hopkins Hospital, then studied in England, Holland and Germany. He returned to Buffalo Medical School in 1929. During World War II, Dr. Beck served in the Army Medical Corps in the North African theater and in the invasion of southern France; he attained the rank of lieutenant colonel. He is survived by a brother, Dr. Edgar C. Beck.



## LABORATORY ANIMAL LAW REPORTED A BENEFIT

An increase in the supply of laboratory animals for scientific purposes to the point where the New York State Society for Medical Research considers it "almost adequate," was reported by New York State Health Commissioner Herman E. Hilleboe, M. D., as a result of the first six months of operation of the law providing that unclaimed animals in state-supported pounds may be turned over to approved laboratories for medical experiments. The commissioner reported that, besides a material increase in the numbers of experimental animals, particularly in New York City, the state-approved competition had increased the available supply on the private market. Quarterly inspections, required by state regulations, had shown animals' quarters to be generally adequate and had revealed general co-operation by the laboratories in giving proper care to experimental subjects, the commissioner's announcement said.

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## WILLIAM DRAYTON, JR., M. D., DIES IN PHILADELPHIA AT 72

Dr. William Drayton, Jr., Philadelphia psychiatrist for many years, died in the Veterans Hospital in Coatsville, Pa., on March 17, 1953 after a long illness. Dr. Drayton, 72 years old, became widely known in forensic psychiatry after his appointment in 1926 as psychiatrist to the medical department of the Philadelphia municipal court, where he made many appearances as a commonwealth witness. He leaves his widow, Dr. Winifred B. Stewart of Philadelphia.

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## VIENNA PSYCHOTHERAPY ASSOCIATION REVIVED

The Vienna society known as the *Allgemeine Aerztliche Gesellschaft für Psychotherapie*, which was dissolved by Hitler, has been revived, according to a communication received by Wladimir Eliasberg, M. D., of 151 Central Park West, New York 23, N. Y. The original society, founded by Dr. Eliasberg in 1926, held seven congresses before its suppression by the Nazis. The new society, according to the communication from Dr. Viktor E. Frankl, president, has voted to make Dr. Eliasberg an honorary member. The original society is said to have been the first amalgamation into a covering organization and the first institution of a common forum of the various schools of psychotherapy current when it was founded. Dr. Eliasberg informs THE QUARTERLY that he still has the records of the seven original congresses and that they are of considerable value for the history of psychotherapy.



## GENERAL SEMANTICS WORKSHOP IN AUGUST

The tenth summer seminar-workshop in general semantics of the Institute of General Semantics has been announced for August 15 to 30, 1953, with an optional post-session from August 31 to September 3. The sessions will be conducted at Bard College, Annandale-on-Hudson.

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## DR. SAMUEL FEIGIN, NEW YORK CITY PSYCHIATRIST, DEAD

Samuel Feigin, M. D., widely known for many years in New York psychiatric circles as a practitioner and consultant, died March 20, 1953 in Palm Beach, Fla., where he had been convalescing following a heart attack. He was 58.

Dr. Feigin, a graduate of New York University College of Medicine, had a long record of public service. He interned at Bellevue Hospital, New York City, was on the staff of Manhattan (N. Y.) State Hospital; and was assistant and then acting director of the psychiatric division at Bellevue for 14 years. Among other activities, he reorganized the psychiatric service of Kings County (N. Y.) Hospital; assisted in organizing the psychiatric clinic at the New York County Court of General Sessions; was psychiatric consultant for the New York City Board of Education and was psychiatrist for the New York City Police Department.

He was past president of the New York Society for Clinical Psychiatry and a member of other professional societies. He had devoted himself to a large consulting practice in recent years. Dr. Feigin leaves his widow, a son and three brothers.



## THE ROLE OF THE PSYCHIATRIST IN A GENERAL HOSPITAL\*

BY M. RALPH KAUFMAN, M. D.

It is indeed a great honor to have been invited to be the Richard H. Hutchings memorial lecturer. Dr. Hutchings was already one of the grand old men of American psychiatry when I began my own training in the New York State hospital system many years ago. It was my pleasure to know him personally, although I could never count myself one of his intimate friends. To me, as a psychiatrist, who is also a psychoanalyst, Dr. Hutchings has a unique place in American psychiatry, since he was one of the early pioneers who recognized the importance of Freud's psychoanalysis and ably presented a psychodynamic point of view to American medicine. It would be impertinent for me to elaborate further on his many virtues as a man, as a physician, and as a psychiatrist.

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The writer has selected the topic of the psychiatrist in a general hospital setting for discussion here for a number of reasons. The first and foremost is perhaps that this aspect of psychiatry has been a major personal interest for many years—through personal relationship to the Harvard Medical School under Dr. C. Macfie Campbell, and later Dr. Harry C. Solomon, through whose joint influence the writer first became interested in the general hospital as a psychiatrist—at Massachusetts General Hospital and then at the Beth-Israel. Even as a resident at Boston Psychopathic Hospital, which lies at the periphery geographically, of the cluster of general hospitals surrounding the Harvard Medical School, there were many occasions to answer consultation calls from these general hospitals. The type of cases that the psychiatrist was called in to see is a commentary on the changing climate of medicine in its relationship to psychiatry.

At the present time, the writer has the privilege of working in collaboration with a fairly large group of psychiatrists and adjacent personnel—psychologists, caseworkers and others—in The Mount Sinai Hospital, New York City. This service, as at present organized, was first instituted in 1946, although Mount Sinai has had a long tradition of psychiatry as part of its over-all function.

\*The Fourth Annual Richard H. Hutchings Memorial Lecture, Syracuse, N. Y., October 6, 1952. From the department of psychiatry, The Mount Sinai Hospital, New York City.



As a matter of fact, the current issue of *The Mount Sinai Journal* has an article entitled, "The Jews' Hospital and Psychological Medicine,"<sup>1</sup> which is of historical and chauvinistic significance since it reports several psychiatric cases from the first case record book of The Jews' Hospital, as Mount Sinai was then known, about one hundred years ago. It was one of the first hospitals in this country to institute a psychiatric out-patient service—under the direction of Dr. Clarence P. Oberndorf. The presence of a psychiatric unit in a general hospital is not something new, since there are many general hospitals which have had psychiatric divisions for many years. However, by and large, these psychiatric divisions were only geographically, and not functionally, related to the hospital. There are a number of reasons for this, and perhaps, in stating these reasons, the thesis will also have been presented for the present discussion.

There is an interesting relationship between the times and basic scientific concept. Somehow the intellectual and emotional climate at a given time in the history of science must be right in order that certain fundamental changes in theoretical concepts be accepted. It is not always certain that an apparent new truth becomes self-evident and acceptable. If neither the time nor the basic concept is appropriate, then it may happen that two aspects within a given discipline may exist side by side without having any intrinsic relationship to each other. The writer believes that this is so in the relationship of psychiatry to medicine; however true it may be, as has sometimes been stated, that since "traditionally physicians have descended from the witch doctor, the shaman, and the priest . . .," and, therefore, "since our ancestors treated by incantation and exorcisement, the psychic factor in the disease process has always been recognized. Indeed it would seem on superficial examination as if at one time in the history of medicine psychogenic factors were the only ones that were considered."<sup>2</sup>

As the writer has stated elsewhere, in an article from which the foregoing is an excerpt, he believes that to a great extent this is a misreading of history, since the witch-doctor may have thought of possession by a demon in an actual physical, rather than psychological sense. Be that as it may, medical textbooks have for centuries emphasized the role of emotional factors in all types of syndromes. This in itself, however, was not sufficient to relate the psychiatrist to the general body of medicine. He, on the other hand, either



through design or acquiescence, considered his special field to be restricted to the mental disorders as such and dealt both on a theoretical and pragmatic level with disease entities that manifested themselves, by and large, in disturbed behavior patterns that necessitated the withdrawal, either voluntarily or by coercion, of psychiatric patients from the community. It was only when a new frame of reference was brought into being by Freud, in his epoch-making clinical observations and theoretical conclusions, which made for a psychodynamically-oriented psychology of the human individual (and which in this country were paralleled, but not always in agreement, by the series of basic concepts constituting the psychobiology of Adolf Meyer), that the theoretical concepts enabled the psychiatrist to understand a broader spectrum of human behavior and allowed him to come into a closer relationship with medicine. Primarily this relationship was based on the fact that the physician as such has always had the task of treating not only disease but people.

The writer has already referred to his experiences as a resident in Boston in the role of a consultant. He well remembers, or perhaps since he is anxious to prove his point, should say that he remembers only, that when one was called in to see a patient it was because that individual was manifesting overt behavior of such a disturbing nature that even the medical interne could make the diagnosis of "nuts" (quote only); or else that the patient to be seen had become a management problem, and, therefore, the primary reason for calling in the psychiatrist was that he by law could sign certain colored papers under certain sections of the law which then enabled the hospital to be rid of a troublesome patient. This, of course, is an exaggeration to make a point, but essentially it represents the situation not too many years ago.

With the advent of a clinical and theoretical point of view, which incidentally Dr. Hutchings saw rather early and represented in American medicine, it became possible for the psychiatrist to enter into the great stream of American medicine. The psychiatrist became interested, not only in the dementia præcox cases and the manic-depressives and the unclassified psychotics, but also in patients and individuals who presented somatic complaints, in which there was no question about organic pathology, since organic pathology could be demonstrated in many of these patients through adequate medical examination. He became interested in the indi-



vidual and in the complex psychological and emotional factors which might etiologically and concurrently relate to all forms of illness. The two world wars contributed to this interest. Many psychiatrists know from personal experience the tremendously important role that psychiatry played in World War I and World War II, not only in the process of selection and treatment of the straightforward psychiatric syndromes, but also in all aspects of the practice of medicine. Many physicians were impressed by these observations and evinced an interest and sympathy for the psychiatric point of view.

Psychiatry, then, has become a kind of basic science in medicine, in many ways not unlike physiology and biochemistry. Psychiatry, almost by definition, has become an integrator and catalyst in the teaching of medical students, the training of residents, and the practice of medicine. The writer is not going to discuss psychiatry as a basic science here, but rather the psychiatrist's role as integrator and catalyst. Psychiatrists are all familiar with the field of so-called psychosomatic medicine, and its implications for the practice of medicine at all levels.

To return to the role of the psychiatrist in the general hospital: As a colleague of equal status with all other physicians in a general hospital, he is called upon to participate in the full activity of the hospital. Only by way of illustration, the writer would like to refer briefly to the organization at Mount Sinai Hospital. Administratively and functionally, the service is divided into several units—a 22-bed open ward in-patient service for adults, out-patient psychiatric clinics for adults, and what the writer believes to be the most significant division for the role of psychiatrists in a general hospital, a section of liaison psychiatry, whose psychiatrists are assigned to out-patient clinics and in-patient services other than the psychiatric service. There is a division of child psychiatry which is a smaller replica of the adult service. Perhaps the best indication of the role of the psychiatrist in a general hospital would be to indicate the type of patients, in terms of primary diagnosis, that are referred to the psychiatric service for whatever additional diagnostic and therapeutic measures the psychiatrist can offer, as a specialist, to the surgeon or the physician. In a previously published paper, the following patients with their diagnoses were listed:<sup>3</sup>



- "1. Ulcerative Colitis  
Psychoneurosis (obsessive-compulsive with depressive features).
- "2. Ulcerative Colitis  
Mental deficiency (obsessive-compulsive personality).
- "3. Manic-depressive (depressed, hypochondriasis).
- "4. Essential Hypertension  
Schizophrenic, catatonic.
- "5. Anorexia Nervosa.
- "6. Fugue State, questionable catatonic schizophrenia.
- "7. Ulcerative Colitis  
Obsessive-compulsive personality.
- "8. Diabetes Mellitus  
Psychosis with depression and paranoid trends.
- "9. Postgastrostomy  
Hysterical personality type.
- "10. Psychosis (paranoid state, somatic delusions).
- "11. Ulcerative Colitis  
Schizophrenia, type unclassified.
- "12. Coccygodynia  
Psychoneurosis, conversion hysteria.
- "13. Duodenal Ulcer—postvagotomy and gastroenterostomy  
Passive-dependent personality.
- "14. Duodenal Ulcer  
Passive-dependent personality in adolescent boy.
- "15. Rheumatoid Arthritis, Amyloidosis  
Psychoneurosis, obsessive-compulsive.
- "16. Hyperthyroidism  
Chronic anxiety state.
- "17. Gastric Ulcer—postvagotomy and gastroenterostomy  
Psychoneurosis, hysteria.
- "18. Psychoneurosis (conversion, cardiac symptoms)."

This was an unselected group in the sense that it represented the patients on a ward of the psychiatry service on a given day. One has but to read the list of primary diagnoses to realize how far psychiatry and medicine have advanced in the utilization of basic psychiatric concepts in the practice of medicine. Here we see patients whose primary illnesses do not fall into the well-known psychiatric syndromes. Actually, it is only rarely that a patient with a schizophrenic or a manic-depressive psychosis finds his way to



the psychiatric service. This is because the basic philosophy, as a psychiatric unit in a general hospital, is to be primarily of service to the population of such a general hospital. Therefore, the psychiatrists work with those patients who come to the hospital, and most patients come to a general hospital because of illnesses whose symptomatology is primarily expressed in somatic manifestations.

The liaison psychiatrist in Mount Sinai, assigned to all services of the hospital, is at the very forefront of psychiatry, since his only duty is to work intimately with the attending and resident staff of each service, whether surgery, medicine, or one of the specialties. He is a free agent in the sense that he does not have to wait until he is called, but, being part of the over-all medical team, he is privileged to work with every patient on the service and to give whatever help is indicated whether at the diagnostic or therapeutic level. A parallel series to the one just given of patients whose primary diagnoses are as follows can be listed to illustrate some of the problems he deals with:

1. Sprue  
Neurotic character.
2. Hyperthyroidism  
Language barrier, plus conscious refusal to discuss self, anxious, depressed.
3. Myocardial Infarction  
Depressed because dependency wish frustrated on being sent home.
4. Pancreatitis  
Reactive depression.
5. "ACTH" Psychosis  
Psychotic reaction (ACTH) in case of lupus.
6. Contact Dermatitis  
Psychosomatic outlet for severe neurosis and depression.
7. CA of breast  
Anxiety state, no suggestion of danger of post-amputation depression.
8. Post-Cholecystectomy; long hospitalization; suicide threats  
Moderate reactive depression; no suicidal danger.



9. Depression—post-hysterectomy  
Anxiety neurosis, depression, severe; refer to Psychiatry OPD.
10. Hemi-paresis  
Conversion hysteria, recommend suggestion, reassurance, early ambulation.

Here again one sees that the psychiatrist in a general hospital relates himself to every aspect of the practice of medicine. His importance to the surgeon is to help him understand what is going on in a given individual. For instance, in elective surgery, he may give an opinion on whether or not the emotional factors are such that the procedure should be carried through; occasionally the psychiatrist is placed in the position of making the ultimate decision, not as to whether the patient needs surgery, but as to whether surgery should be carried out at a particular time. The psychiatrist or the psychiatric service may be assigned the task of preparing a patient to accept with a minimum of trauma the necessary surgical procedures.

One of the basic facts of life in regard to a psychiatrist in a general hospital is the simple and pragmatic one as to whether he is of any value to the other members of the staff. The surgeon or the internist is not interested, except in an academic way, as to what the psychiatric diagnostic label is or in what, to him, very frequently is an esoteric evaluation of psychodynamic factors for their own sake. He is, however, interested as a physician and as a practitioner of medicine in a colleague's help to understand and to be of practical assistance in the total evaluation and furtherance of treatment of any given patient. However, it must be emphasized that the practical help which a psychiatrist renders is but one step in his total integration into the general hospital. One can carry practicality too far and end up by having a highly mechanized approach to the problems of medical practice in a hospital. As the writer has stated before, a psychiatrist is a catalyst, an integrator. He has a great deal to contribute to medicine, but his contribution must be made primarily as a psychiatrist. The writer has no patience with the type of psychiatrist who tries to smuggle himself into medicine under false colors and who feels that it behooves him to demonstrate to the surgeon or to the internist that after all he, too, is a top internist or surgeon. A knowledge of medicine is essential, but no psychiatrist that the writer knows will



ever convince any internist, even a mediocre one, that he, too, knows the normal value of NPN. At the present time, although the approach is a holistic one, it is nevertheless impossible for every physician to be an expert in every branch of medicine, and one does not "sell" a psychiatric point of view if one disguises himself with a false face and pretends to erudition that is essentially superficial. The psychiatrist is a psychiatrist, just as the surgeon is a surgeon; and it is only as a psychiatrist, standing firmly based on his own discipline, that he can eventually demonstrate the value of his orientation in the understanding and treatment of patients.

At Mount Sinai, the psychiatric in-patient service is considered as only a minor part of the total psychiatric function. The psychiatrists endeavor to work with the patients on the parent services and to maintain the professional relationship of the surgeon or internist to those patients. The psychiatric contribution, if any, is to demonstrate to the internist that an understanding of the patient as an individual will enable the internist to function at his fullest capacity as a physician. The writer can cite many instances in which the psychiatrist on the various services of the hospital was able to contribute specifically in his role as psychiatrist, and as illustrations, would like to present the following incidents, reported by members of our staff.

### *Case 1*

The patient was a 40-year-old, married woman who was admitted to the hospital with the complaint of pain in the abdomen and pain in the back. She was compelled to assume a grotesque, camp-tocormic posture while at the same time attempting to stroke an area in her back and in her abdomen where she complained of pain. She received extensive medical, and a surgical, workup. No abnormality to account for her symptoms was discovered. When her bizarre posture and the following personal history were put together, psychiatric consultation was requested.

The history was that this patient had made a hasty second marriage during the war, to a previously unmarried army sergeant. During the war, she lived comfortably on allotments from him and small supplementary earnings. On his return, he demanded his marital rights, and her disability promptly began. It was suggested that the woman's posture was well calculated, so to speak,



to prevent the marital intimacy which her husband expected. The psychiatrist was impressed by the following features: (1) She gave a straightforward account of her symptoms, including her primitive regret at having made a bad marriage to a man she did not like; she had handled her dislike of her husband in a furtive and evasive way, never quite confessing to him that she was frightened by his advances. There were other factors to indicate that basically she was a neurotic, inadequate woman. (2) There was no history that somatic disability, other than that of headaches, or "nervous indigestion," had been used as part of her reaction to an affectively-charged situation. Her reaction to her illness and pain was that of a search for a clinging and helpless dependency. This behavior was characteristic of her in more stressful situations. Her description of her pain did not have the fantastic elaboration oriented toward specific avoidance, or toward negation of, sexuality. (3) The psychiatrist, therefore, concluded that although the woman was neurotic and inadequate, she exhibited a reaction to an organic process that was appropriate for her neurotic personality. He suggested that this woman was suffering from an organic, intra-abdominal, undiagnosed process and that in addition she had the severe character disorder which her physicians recognized. Upon this basis, an exploratory laparotomy was performed, and carcinoma of the head of the pancreas was discovered.—(Notes from Sydney G. Margolin, M. D., liaison psychiatrist on the medical service.)

### *Case 2*

A 'teen-aged girl on the ear, nose and throat service had a nasal plastic operation with a pedicle graft from forearm to nose, necessitating a cast and traction of the left upper extremity. Following this operation, she complained of sensory and motor disturbances of the left hand. This constituted a diagnostic problem of considerable importance: true neurological defect would require sacrifice of the operative gain; if the symptoms were on the basis of psychoneurosis, the operation need not be sacrificed if the patient's co-operation could be obtained. Because it seemed too early for signs to have developed, even if nerve injury had occurred, the neurologists in consultation could not be certain that the symptoms were on the basis of nerve damage. In their opinion this was most likely a hysterical conversion syndrome. The psychiatric examina-



tion revealed that this young woman did indeed suffer with a psychoneurosis of hysterical type. However, this did not necessarily explain the present symptoms. Hypnosis on two occasions served to satisfy the psychiatrist that the parasthesias and motor disability were on a neurological basis.

This information was of definite value in providing the ear, nose and throat service with specific diagnostic information on which to base a decision of major importance. A decision to sacrifice the pedicle graft followed.

In terms of follow-up, it seems likely that there was a second gain from psychiatric help, in that during hypnosis strong suggestion was made to the patient that the graft would succeed and that circulation would improve in the operative area. While this sequel may be questioned, the fact that the graft took, after an unusually brief attachment for collateral circulation, points to the probable efficacy of this suggestion under hypnosis. During the trying period in which the patient's panic was increased by the concern of her doctors and her family, the availability of a psychiatrist to provide reassurance and decrease her fear was of the utmost importance for the comfort of the patient as well as for the success of the procedure and maintenance of good patient- and family-hospital relationships.—(Notes from Alvin I. Goldfarb, M. D., liaison psychiatrist on the otolaryngology service.)

### *Case 3*

A man in his early 30's was admitted to the surgical service for operation for a lung abscess. He was seen in consultation by the psychiatrist because of the patient's conviction that he would not survive the operation. This was remarkable in view of the fact that the patient had served in three armies—Polish, Free French, and American—during World War II, had undergone an emergency appendectomy during military action and had been subjected to countless real dangers during this time, without suffering any evident neurotic manifestations. It was impossible to dissuade the patient from his conviction or to expose the groundlessness of his fears.

During an interview, the following information was elicited. Shortly after the close of the war, the patient fell in love with a Dutch girl, caused her to become pregnant and then married her. Not long thereafter, he had an opportunity to come to the United



States which created for him a severe dilemma—whether to proceed to America alone, establish himself, leaving his wife in Holland until after the baby was born, or remain there with her. She urged the former course, and he reluctantly complied. After establishing himself in America, he learned that a son was born. Unfortunately, about two weeks later, the baby contracted a pulmonary ailment and died. He castigated himself for leaving his wife and felt that had he remained on the spot his connections with American medical personnel in the army would have avoided this tragedy. Although little attempt was made to point out the coincidence of these two pulmonary affections, an attempt was made to interpret his conviction that he would die from a chest operation as a manifestation of his remorse and guilt over his son's death. On the day following this interview, the patient, when asked how he felt about the impending operation, smiled sheepishly and stated, "I got over that foolish idea." Subsequently, the patient was operated upon and recovered without complications.—(Notes from Bernard C. Meyer, M. D., liaison psychiatrist on the surgical service.)

#### *Case 4*

A 49-year-old woman was transferred to the surgical service from gynecology for radical vulvectomy and exploration of the deep pelvic nodes because of malignant melanoma of the vulva. She had been told of the presence of malignancy, and that the chances were good that the tumor would be completely removed and would not recur. However, she lapsed into an agitated depressed state, and reassurance was of no avail. The surgeons were reluctant to schedule the extensive procedure with the patient so disturbed, and called for a psychiatric consultation.

It was ascertained that the patient's chief concerns were because she was afraid about her ability to urinate normally after the operation, and because she had heard that after the removal of "glands" she would no longer be a woman. She also feared that she would not have a vagina after the operation, that her scars would be ugly, and that she might have "caught" the cancer from swimming in dirty water. She had previously been reluctant to discuss this with her physician; some simple factual explanations were given to her; and diagrams were drawn for her to show what would be involved in the operation, and what would not be involved. The



depression and agitation subsided. During the days prior to the operation, the patient was seen daily, and new questions were answered. Conferences were held with the house staff, in which the patient's psychiatric formulations were discussed in connection with suggestions for managing the case. (Incidentally, this patient's mother had always complained of dyspareunia, and had died of some gynecological condition. The patient had constant pain with intercourse, about which she had never informed her husband; and she had the practice of voiding after intercourse for contraceptive purposes, ascribing her childlessness to the latter procedure.)

The patient underwent the operation uneventfully, and when seen on discharge appeared cheerful and eager to return home.—(Notes from Paul Kaunitz, M. D., liaison psychiatrist, surgical service.)

#### Case 5

A 40-year-old woman was admitted to the hospital because of a melanoma of the vulva. She was apparently inordinately panicky and disturbed at the impending surgery. The gynecologists felt that her fear was in a sense exaggerated and inexplicable, since she repeatedly mentioned the fact that she was quite realistic in her knowledge that this was a serious condition, probably malignant in nature, requiring radical surgery. Within five minutes after the psychiatrist visited her, she blurted out the fact that it was not the fear of malignancy itself, or even death, which bothered her much, but rather the horror of mutilation after which she might find her external genitalia so distorted that "she would no longer look like a woman." When she had confessed this basic anxiety and when she was assured truthfully that no such deformity would result, she was operated on without any undue terror and made a completely uneventful and successful convalescence.—(Notes from Mark L. Gerstle, Jr., M. D., liaison psychiatrist, gynecology service.)

#### Case 6

When a psychiatrist was first assigned to the medical service, he was frequently called to see elderly patients (over 65) who soon after admission showed confusion and a mental picture of disorientation and agitation. Frequently, on the nights of admission, these patients had been heavily sedated with barbiturates. It was explained to the house staff on several occasions about the rela-



tive difficulty older people have in adjusting to new situations, and that transitory confusion, and so on initially did not necessarily mean serious mental disturbance. Some idea of the effect of cerebral arteriosclerosis on cerebral function was given. It was pointed out in this connection how the use of barbiturates would merely increase the cerebral anoxia present and aggravate the overt mental picture. After it was demonstrated to the resident staff how, in several patients, reassurance and understanding, coupled with the use of chloral hydrate or paraldehyde, tided these people over the first day or so of hospitalization with complete clearing thereafter of overt mental symptoms, staff members began to feel more relaxed in dealing with such problems. The result is that now the resident staff deals directly with such problems, and the psychiatrist only learns of them incidentally.—(Notes from Edward D. Joseph, M. D., liaison psychiatrist on the medical service.)

#### *Case 7*

The psychiatrist on the surgical service was making "grand rounds" with the surgeon, who said to one of the patients, "Good morning, Miss G." The patient replied, "You have a nice haircut." Subsequent questions that the surgeon asked the patient about the patient's condition were answered relevantly. However, the psychiatrist was struck by the initial response which was either irrelevant or might have been a kind of friendly impertinence. He decided to study the case further after rounds and found that the patient actually had a mild toxic psychosis on the basis of a prolonged postoperative infection. The psychiatrist was then able to point out to the surgeons the significance of this seemingly innocuous remark of the patient.—(Notes from Paul Brauer, M. D., liaison psychiatrist on the surgical service.)

As another illustration of the role of the psychiatrist in a general hospital, the following brief report by Dr. Louis Linn, liaison psychiatrist on the neurology service, of work that he is doing in collaboration with the ophthalmological and neurological services, is of interest.

"Although psychiatric disturbances following cataract extraction have been known for many years, the problem has not been studied systematically. The psychiatry service in conjunction with the departments of ophthalmology, neurology, electro-encephalog-



raphy, social service and nursing studied 21 consecutive admissions for cataract extraction in an attempt to evaluate factors in the total picture. Twenty of the 21 patients showed evidence of organic brain damage, indicating that cataract is simply one external evidence of a widespread degenerative process, which affects the brain as well as the eye, and probably other parts of the body. So that what started as a psychiatric study contributed inadvertently to our understanding of the pathology of cataract. We covered the eyes of these patients for a 12-hour period pre-operatively. Several patients reacted to this procedure with intense anxiety. These same patients tended to show the most marked psychiatric disturbances post-operatively. It became possible by this means to anticipate which patients would require special nursing care post-operatively. It was repeatedly possible to demonstrate that uncovering the eyes post-operatively had a dramatic anxiety-relieving effect, as did removal of side rails from the beds, early mobilization of patients from their beds and early return to their own homes, all matters of considerable importance from a prophylactic point of view. In addition, the material was instructive from a theoretical psychiatric point of view, shedding light on the psychological mechanisms of defense against anxiety and how these defenses were modified by organic brain disease."

These illustrative incidents come from the clinical experience of members of the staff and are presented as they were reported. Each one of these incidents represents another facet of the many types of problems that confront the psychiatrist in his daily work in a general hospital. There are a multiplicity of problems that arise administratively and professionally for the psychiatrist in a general hospital, but this discussion has touched on only a few. The writer has attempted to present a basic philosophy of the function of the psychiatrist in medicine and to reflect the factors that enter into the integration of psychiatry into medicine. It is his belief that this aspect of psychiatry has opened vast new areas and has posed many questions. It is a tremendous field for new types of research. There is a new possibility for psychiatry to validate many of its basic theoretical concepts through the utilization of the biological techniques inherent in the medical viewpoint.

Psychiatry has come back into medicine as a co-equal member in a scientific discipline and is making a noteworthy contribution. However, this new relationship is confronting the psychiatrist with



the necessity for a reorientation of some of his basic concepts toward a dynamic psychobiological point of view that augurs well for our field.

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## CONSIDERATIONS IN THE DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA\*

BY NEWTON BIGELOW, M. D.

Probably the factors which generally prevent psychiatrists from making a good differential diagnosis (let alone a good diagnosis) in schizophrenia are lack of time to develop a good history, to observe the patient adequately and to consider all of the facts carefully, providing the physician has lived long enough with cases to have developed a keen diagnostic "nose" for the disorder.

The need for a good diagnosis is probably clearest with respect to the initiation of proper treatment. Some patients badly need insulin-coma treatment early. Very frequently, too, the proper differential diagnosis has a strong bearing upon a medico-legal problem in a given case—in respect to prognosis for disability, for example. Finally, scientific progress cannot be made without proper labeling, as in the evaluation of treatment, or even in fundamental statistical research.

Recently, the writer has been concerned with the startling discrepancy in the statistics from the several institutions in the New York State Department of Mental Hygiene, with respect to admission diagnoses. Comparable hospitals serving comparable areas show extreme variation in the percentages, for instance, of admissions of patients with manic-depressive psychosis, as opposed to schizophrenia, or again even with reference to some of the organic disorders. Geographical or cultural differences have not accounted for these variations among the so-called functional disorders and the organic psychoses. At the First Conference on Psychosurgery,\*\* held under the auspices of the National Institute for Mental Health, the matter of diagnosis and comparative statistics in this same aspect also came up. The statisticians and the clinicians expressed themselves then as being alarmed over the variability which existed in the data which came from contiguous states as it related to similar disorders. So far as one can tell at the moment these discrepancies depend primarily upon the personality, train-

\*Address delivered at Veterans Administration hospitals at Northport and Augusta, N. Y.

\*\*National Institute for Mental Health: Proceedings of the First Research Conference on Psychosurgery. Newton Bigelow, M. D., editor. Public Health Service Publication No. 16. Washington, D. C. 1951.



ing and background of the individuals charged with making the official diagnoses. Other factors, perhaps also not inherent in the clinical material itself, undoubtedly affect the reported data as well. By studied, consistent effort, it is probable that some of these factors may be controlled.

The ideal procedure, in order to make a good differential diagnosis, would include: first, a valid history from the patient and his family, containing at the same time a clear picture of his early emotional environment, his family and his pre-psychotic personality. In this connection, Federn\* quotes Schwing's sweeping generalization "that all schizophrenes did not have true mothers," which contains more than a kernel of truth. Thereafter, thorough psychiatric, physical, neurological and laboratory examinations would be required, followed by a psychological work-up, including particularly the Rorschach test and any other indicated procedures. These data should then be supplemented by the patient's response to therapy, if by this time the diagnosis is not already sufficiently clear. It is also believed that the patient's reactions to certain substances will soon be an aid in regular diagnostic routine. Finally, time will help to clarify the diagnosis in a certain number of cases. Parenthetically, it does not seem to indicate, to the writer, shiftlessness for a psychiatrist to label a few difficult cases at the end of the year as undiagnosed psychosis if he can conscientiously say that the diagnosis is still not clear. A random review of 50 patients diagnosed five years back would furnish the reason for the last statement.

In attempting to decide that a given individual is suffering from schizophrenia, one should first rule out organic disorders. Certainly, with the procedure just outlined, little difficulty will be encountered except in the rare instance. The parietic with a schizophrenic set of symptoms is easily excluded by the organic psychiatric findings, the psychological report and, of course, by the serological and neurological positive findings. The paranoid arteriosclerotic is usually betrayed by his typical emotional lability and organic mental signs. Occasionally pre-senile patients present difficulty, particularly in the very early stages. Here, again, careful psychiatric, psychological and neurological examinations will point the finger at the proper etiology. Later, with x-ray and biopsy

\*Federn, Paul: *Ego Psychology and the Psychoses*. Edoardo Weiss, editor. Basic Books. New York. 1953.



findings and the full development of all the signs and symptoms, the differential diagnosis is not difficult in the average case.

Long—and questionably—included in the organic group, are those patients labeled involutional psychosis, paranoid type. If one is conscientious, the writer believes that diagnosis of a certain number of these will give trouble. A few are very close to schizophrenia of the paranoid type, and there is the rare case which looks quite a bit like the so-called paranoid condition. But the character of the prodromal period, the inclusion in these patients of some typical involutional features and the complete setting will generally allow one to discriminate. Finally, these people do not do well on electric shock therapy, as opposed to the usual response of the paranoid schizophrenic.

Also, in the organic group, one must consider acute hallucinosis. The history and course in the usual case clinch the diagnosis. However, there are patients who are quite schizophrenic in their appearance. There are others who show overt symptoms and voice trends only while imbibing alcohol. Some time ago, a number of writers argued that the typical case should be placed either with the schizophrenic or with the manic-depressive disorders, indicating the clinical uncertainty which exists here. Noyes\* expresses, as follows, his doubts about placing the paranoid reaction in the schizophrenic group: "Clinically it is convenient to describe an alcoholic paranoia, although its recognition as a true alcoholic psychosis is scarcely justified."

The paranoid condition has been mentioned. Here again, the need for a careful chronological history of the evolution of the personality and of the disorder is very necessary. The elaboration of the trend which, if one grants the original premise, would not be too inconsistent with reality, and the preservation of the personality are the signs ordinarily relied on for differentiation from dementia præcox. Admittedly, however, the differential diagnosis is difficult.

The manic-depressive psychosis very frequently poses a considerable differential diagnostic problem. Qualified psychiatric examiners are frequently in sharp disagreement over a given case where most of the facts are at hand. Again, the need for a careful history of the personality development to show the presence of either the characteristic cyclothymic or schizoid make-up is the first

\*Noyes, Arthur P.: *Modern Clinical Psychiatry*. 3d edition. Saunders. Philadelphia and London. 1948.



essential. Prolonged mood swings in the history are likewise significant. Comparison, by the trained observer, of the trend of the manic as opposed to that of the productive schizophrenic can often distinguish the disorders. The degree of empathy present in the manic-depressive case is relied on by many but is purely a subjective matter, in our present state of knowledge. Some observers have had considerable to say about clouding of the sensorium in the acute stages. Others have quarreled with this view. The need to distinguish between apathy and depression, the need to recognize a depression masquerading as a somatic syndrome and the need to distinguish between the purposeless behavior and verbigeration of the schizophrenic, as opposed to the purposeful activity and flight of ideas of the manic, are shown by the use of the adjective, "pseudo-affective," and the former diagnosis, "allied to dementia præcox." Finally, all of us are given pause by the occasional case of a patient with manic-depressive psychosis, who, as he grows older, has severe manic attacks with greater frequency and gradually presents a chronic paranoid disturbed state.

The differential diagnosis between the psychopath and the schizophrenic occasionally causes difficulty, particularly if the individual has transient episodes of the paranoid variety. The history, the "cold amorality," the usual explosive emotional reaction and the absence of characteristic trends generally clarify the diagnosis. Psychological tests may aid therein.

It is when we come to the psychoneuroses that we frequently have our greatest trouble. In the writer's mind, the psychoneurotic and the schizophrenic processes are separate, individual developments, although experience during World War II would tend to negate such a conclusion. It is admitted, too, that the obsessive-compulsive is a first cousin to the schizophrenic. Further, it should be remembered that most personalities present some admixture of neurotic traits, which of course will not exclude the development of a schizophrenic process if the constitutional endowment is right and the current situation explodes it. Neurotic symptoms occasionally serve as a defense mechanism in latent schizophrenia.

To differentiate the psychoneurosis from schizophrenia a longitudinal view of the individual is again most necessary. The story of the development of the disorder is likewise most pertinent; and, in the difficult case, careful, time-consuming, repeated examinations alone may allow one to see the essential facts.



Writing on the subject of the differentiation of the psychosis from the psychoneurosis, Henderson and Gillespie\* list some of their criteria. They point out first that in the psychoneurosis only part of the personality is involved, whereas generally there is a change in the whole personality in the psychosis. They go on to say that frequently there is no outward change in the individual suffering with a psychoneurosis, whereas generally this cannot be said of the psychotic individual.

For the psychoneurotic, reality has the same meaning as for the rest of the community. Thus, although there may be some quantitative change in the psychoneurotic, the qualitative change as seen in the psychotic is not apparent. They make the further point that rarely does one find distortion of language in the psychoneurotic. So far as the psychoneurotic is concerned, unconscious material gains only symbolic expression. Frequently in the psychotic, unconscious material is crudely manifested. It is also pointed out that true regression is seen in the psychotic patient. This does not occur in the individual suffering with a psychoneurosis. Even though the degree of insight is not great, most psychoneurotics recognize that they are ill, and a good number have some understanding, vague as it may be, as to the nature of their illness. It is true that some schizophrenics recognize that there is something wrong with them, but rarely can they identify the morbid site.

Here, then, are some general guideposts for sizing up the given case. They are not exact and certainly do not apply *in toto* to any one individual.

It is probable that speculation as to etiology does not help us with the diagnostic procedure. However, clear recognition of the dynamic mechanisms involved is essential in analyzing the forces at work in the case before us, and interpreting correctly the past behavior of the individual. His psychosexual development, his basic conflicts, his reaction to frustration, his handling of hostility, his responses to anxiety-laden situations all may give a key to the puzzle. From another view Muncie,\*\* in discussing the essential nature of schizophrenia, said that "Bleuler named the reaction schizophrenia, by which he aimed to stress the most striking clini-

\*Henderson, D. K., and Gillespie, R. D.: A Textbook of Psychiatry for Students and Practitioners. P. 151. 7th edition. Oxford University Press. New York. 1950.

\*\*Muncie, Wendell: Psychobiology and Psychiatry. Pages 388-9. Mosby. St. Louis. 1939.



cal features and, as he thought, also the mechanism involved, in a splitting of the associative processes. He eventually had to assume a basic gliosis and his later contributions point to a dichotomy of 'primary' symptoms on an organic basis, and of 'secondary' symptoms, an essentially psychological superstructure." Thereafter, Muncie stated in the same discussion: "Meyers' concept of essential habit deterioration on a basis of a peculiar constitutional make-up has been the most useful theoretical foundation for modern work."

Schilder states very definitely with reference to the nature of the schizophrenic process, "I am convinced that schizophrenia is in the same sense an organic disease as is the manic depressive psychosis." He goes on to say, "I prefer to emphasize that in schizophrenia the basic functions pertaining to perception, action and judgment are chiefly perturbed by the conflicts and the regressions. This is a fundamental difference from the psychic disturbances one finds in organic processes affecting the brain tissue. I prefer to call the psychological disturbances observed in these cases, disturbances in the ego function." Federn\* writes even more directly: "Metapsychologically, the primary schizophrenic process appears to be a functional deficiency, or even exhaustion, of ego cathexis; secondarily, it is used as a defense mechanism." And again: "In psychosis, the main damage consists of the loss of cathexis (mental energy charge) of the ego boundaries. As a consequence, we find in this condition a narrowing of the extent of the mental ego, ideas and concepts being still preserved; but the same ideas which normally form within the mental ego boundary and, therefore, are apperceived as mere thought, at once take on the character of a false reality when they occur outside the ego boundary. As the loss of the ego boundary cathexis becomes definite this false feeling of reality takes on the quality of being beyond any subjective doubt."

Thus, whatever one's orientation, in attempting to differentiate a schizophrenic process from a psychoneurotic disorder, it is necessary to develop a clear picture of the underlying psychopathology.

From the purely descriptive standpoint again, the observation of irrational behavior or the valid report of such behavior may be very good evidence of a psychotic process, despite one's inability to demonstrate the classical trends or symptoms. This fact is

\*Ibid.



often forgotten in evaluating a patient, with reference, for instance, to a court action. Reference should be made again here to the lack of empathy ordinarily obtaining in the relationship between the schizophrenic and the therapist. This function is subjective and belongs in the field of clinical intuition, but many successful practitioners in the era prior to our present laboratory and gadget period owed much of their success to clinical intuition. There should be little difficulty in differentiating the apathy of schizophrenia from the *belle indifférence* of hysteria, it may be added.

In further evaluating such cases, it is essential to distinguish between the somatic complaint and the somatic delusion. A little time and understanding will enable one to form the proper judgment. Some neurotic fears are also difficult to distinguish from delusional formations. In one's thinking, it is necessary to separate carefully the dissociation in schizophrenia from that entirely different process in hysteria. The need to distinguish the conversion symptoms, or the compulsive ritual, from the schizophrenic mannerism is also worthy of note.

Most conscientious clinicians today are very loath to make a diagnosis of neurasthenia, although there is no doubt that the syndrome does exist. The writer believes that this tendency is a reflection of the fact that in the past many so-called neurasthenics eventually proved to be hebephrenics. The same contention can be applied very aptly to hypochondriasis. It is the writer's belief also that most hypochondriacs are early schizophrenics.

Hoch and Polatin\* have described one group of schizophrenics who strongly resemble neurotic patients. The writer believes that all of us have known individuals of this type, have misdiagnosed them and probably have mistreated them. Hoch and Polatin, in describing the process, point out that these patients show no deterioration and no trends. However, if they are followed long enough they are observed to suffer brief psychotic episodes, and later some develop frank schizophrenic pictures.

In this paper, Hoch and Polatin refer to Bleuler's basic schizophrenic patterns, specifically the primary symptoms of schizophrenia. These include disorders of association, rigidity of affect, ambivalence, and dereistic thinking. The authors remark that

\*Hoch, Paul, and Polatin, Phillip: Pseudoneurotic forms of schizophrenia. *PSYCHIAT. QUART.*, 23:2, 248-276, April 1949.



many psychiatrists are uncomfortable about a diagnosis of schizophrenia unless Bleuler's secondary symptoms, trends and motor signs, are present. They go on to say, however, that the primary symptoms are the essential ones and that in this group of cases evidence can be adduced of the presence of these if careful study is undertaken. They point out that with sodium amytal the presence of inflexibility of affect and even occasionally of some trends, can be demonstrated. In a certain number, the Rorschach responses are helpful, particularly in those showing unpredictability, variability, and the so-called "contaminated responses." Outbreaks of hostility, particularly toward parents, the existence of what Hoch and Polatin call "pan anxiety" and "pan neurosis" are, they feel, significant findings. Careful examination will also show condensations, concept displacements, feelings of omnipotence and vague, contradictory explanations of symptoms, in contrast to the careful explanations given by the usual psychoneurotic. Review of the histories usually indicates good evidence of psychosexual immaturity. The authors emphasize that the superficial appearance of such a case is that of a classical psychoneurosis, that the usual symptoms are present in over-abundance and that the patient may go on for years presenting such a picture.

The writer wishes to close these remarks by emphasizing again that the chief requirement for a good differential diagnosis of schizophrenia is ample time—time to develop and review a good history, time to examine carefully and observe the patient, and time to consider all of the facts fully.

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## FEMALE TRANSVESTISM AND HOMOSEXUALITY\*

BY HYMAN S. BARAHAL, M. D.

There is relatively little in the literature on the subject of transvestism, particularly the female type. A definition of terms would appear to be indicated in order to differentiate this manifestation from the related, but dynamically different, condition known as fetishism.

Karpman,<sup>1</sup> in a lengthy report on a case of transvestism, refers to the condition existing in individuals who are heterosexually inadequate and who, in order to relieve themselves by masturbation, dress in the clothes of the opposite sex, this desire to wear the other sex's clothes disappearing as soon as the masturbatory act is completed. One would question the correctness of referring to this as transvestism, as it is more in line with the concept of fetishism. The transvestite generally assumes the role of the opposite sex because of strongly ingrained inner emotional needs which are not subject to fluctuating changes to meet temporary requirements. Fenichel<sup>2</sup> refers to transvestism as a masochistic perversion and quotes the ideal figure, Hercules, clothed in woman's garments, and serving his mistress, Omphale. He believes that there is some relationship among transvestism, fetishism and homosexuality. The fetishist, he states, is unable to accept the lack of a penis in women; can love only when he has supplied his female love object with a symbolic penis. The male feminine homosexual, also because of castration anxiety, is incapable of loving a being without a penis and therefore solves his Oedipus complex by identifying with his mother and seeking the love of father or a substitute. According to Fenichel, transvestism has a two-fold significance, fetishistic and homosexual. Instead of coitus with the mother or her substitute, the fetishist enters into a relationship with her clothes which he brings into close relationship with his body, particularly his genitals, the patient himself representing a woman with a penis. Fenichel makes a significant statement, "It is true that this hypothesis makes feminine perversions and the whole subject of the castration complex in women all the more problematic. Indeed,

\*Read at the Downstate Interhospital Conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, April 8, 1952. This paper also embodies the views presented in a paper before the Society of Medical Psychoanalysts, January 31, 1952, at the Waldorf Astoria Hotel, New York City.



one receives the impression that they are, to some extent, different in character from perversions in men. Female transvestists seem to be simply women who covet the penis and, out of the desire to possess it, have identified themselves with men."

London and Caprio<sup>3</sup> speak of transvestism as a form of compulsion neurosis in which the patient's desire for the genitals of the opposite sex is displaced to the clothing of the opposite sex. A similar view is expressed by Stekel and Gutheil,<sup>4</sup> when they refer to cross-dressing as a desire to be identified with the opposite sex.

Although when superficially considered, there seems little question as to what constitutes transvestism, the problem becomes more complicated on further study.<sup>5</sup> Generally speaking, the trouser type of garment is considered male and the skirt female. This has not always been the case; and throughout the history of mankind there have been periods during which both men and women have normally worn clothes which today would be looked upon as demonstrating transvestism. Even in modern times, among the most northerly races, trousers are worn by both sexes alike. Further south, the men retain the trousers, and the women assume the tropical or skirt garb. In Shanghai, women wear trousers, whereas in Hong Kong, only a short distance away, skirts are the correct form of dress. The impression has been offered that the reason for European woman retaining the tropical garb was her relative inactivity, as she was generally confined to the house. However, where women are more active, they don the male type of garment. Belgian women working in mines and Swiss women tending cattle always wear trousers. On the other hand, the males of the Scotch highlands wear the skirt or kilt, as trousers would be impractical in the wet heather. It, therefore, appears quite obvious that when one considers the subject of transvestism, cultural factors have to be taken into consideration. For instance, a certain amount of transvestism is accepted as normal among women in our present day society in the wearing of slacks, short hair and tailored clothes. This may account for the fewer cases of female transvestism than of male reported in the psychiatric literature. Yet any deviation on the part of the male is considered abnormal.

A number of cases of female transvestism have been historically documented,<sup>6</sup> but, unfortunately, the psychological determinants can only be surmised. A woman known as James Barry, Sr., was inspector general of the English Army Medical Department. She



was referred to as "The most skillful of physicians but the most wayward of men." Lady Hester Stanhope, niece of William Pitt and married to Sir John Moore, was known to assume masculine attire. Dr. Mary Walker adhered strictly to masculine dress for 50 years. She was related to James Whitcomb Riley and Robert G. Ingersoll. She was graduated from Syracuse Medical School, entered the Union army and was commissioned as assistant surgeon, undoubtedly the only such commission in the American army until recent times. She later became a well-known feminist and lecturer on the rights of women. Her only marital venture ended in separation after three weeks.

The following is a report of analytic work with a case of female transvestism which in many ways resembles that reported by Stekel and Gutheil, even as to the limitation placed by the patient on therapy. In Gutheil's case, the patient stipulated that she wished to come for treatment, chiefly to get permission to wear men's clothing so that she would have no difficulty with police authorities and that she did not wish to be changed in any way. The present patient wrote as follows to the writer prior to treatment:

"I am always starving for spiritual love, seeing that it is such a crime and sin for me to have sex with a girl. I never did with the ones I loved and respected. But those I did not care too much about, I made them turn against me. This seems to be a crazy way to prove that I really cared. I feel best only when I am neutral and not involved in any love affair. I am love-starved, yet get sick with fear every time I fall in love and it is always with girls. I feel trapped completely and cannot take it much longer. These splitting headaches and conflicts are unbearable. If you can help me to remove these feelings of anxiety and headaches, I will be grateful to you. However, as much as I wish to be helped, I don't want you to change me so that I will begin to wear dresses."

For orientation purposes, a short résumé will be given of this patient's life history. However, the greater part of the material will come from progressive analytic sessions including a very active dream and fantasy life.

This is the case of a 22-year-old girl who was born illegitimately when her mother was only 17 years of age. She has never seen her real father and only recently has learned who he was. Adding to the problem of her illegitimate birth was the fact that her mother lived in a small village where everyone knew her and there was



considerable gossip about her. The mother rejected the patient very early in life, and began to board her with various friends and relatives. Between birth and the age of 14, there were eight or nine such changes of residence, the longest period in one place being about six years between the ages of eight and 14 years with a maternal aunt. She completed the ninth grade at 15, and this terminated her education. Following this, she was self-sufficient in that she worked in various factories or did housework. Since early childhood she has had an ungovernable desire to be a boy and has insisted on wearing boy's clothing. Also since childhood, she has shown sex interest in girls; and, as she grew older, she would become alarmed at such interests and would change her jobs frequently so as to avoid too close contact with girls. When she was 19, she met a passive homosexual male who was in the military service. Just before he was to go overseas, he urged her to marry him so that she would be entitled to his government allotments. They married, but the next day he left for Europe, and she has not seen him since. She had herself admitted to a hospital\* when, on one occasion, she received a letter from her husband that he expected to be discharged from the army within a few weeks and wanted to return to her. She became panicky and sought help.

Analysis was carried on with considerable difficulty because of strong character resistance which persisted for a number of months. Although she gave the superficial impression of being co-operative, there was at first no emotional participation in the relationship on the part of the patient; her manner was formal, exact, polite and over-ingratiating.

### *First Session*

*Dream:* "I'm supposed to have a date with a homosexual girl. She goes home to dress and I'm waiting for her. I wonder whether she will come out in a dress or slacks. I am very glad when she comes out in a dress."

*Associations:* "I don't like girls who wear slacks. I am afraid of their domination. When I was a little girl, I resented my mother going out with men and leaving me home alone. I resented the men my mother went out with. Recently a girlfriend with whom I had been carrying on a relationship, met a fellow and had

\*Pilgrim (N. Y.) State Hospital.



an engagement party. I felt very hurt by it. It was as if she had left me for someone else, a man."

This session would indicate her competitive feelings toward men because they took her mother from her.

### *Second Session*

"I had a fight with a patient who called me a hypocrite for going to church. Just before the fight started, I had a very severe headache. After the fight my headache disappeared suddenly. Whenever I give vent to my anger, my headaches disappear. Maybe I am a hypocrite. When I was a little girl, my aunt, who raised me, kept telling me that I will have to go to church frequently so as not to turn out to be as bad as my mother. I have always resented church. Yet, when I go into a church, I generally have a religious feeling come over me. As a little girl I knew two boys. One was very nice and treated me respectfully; the second one was an effeminate boy who was mean to me. I preferred to go with the second one even though he was no good. I was a tomboy and wanted to play with the boys, but they chased me away. I resented it very much and I used to get headaches. I could have beaten up any one of those boys but didn't.

"Later in life there was a woman I didn't like, and my headaches kept getting worse and worse until finally I beat her up so badly, that she had to go to a hospital. My headaches cleared up immediately. I almost think that the relationship between a man and a woman is such that the woman always gets beaten up. My stepfather used to beat my mother frequently."

This session again indicates her strong need to identify with a man and the sado-masochistic elements of her neurosis. The relationship of her headaches to introjected aggression is rather prominent.

### *Third Session*

"I met a bisexual attendant. The world seems to be full of them. She is a little sadistic and I seem to enjoy that. It almost seems that they like to be mean so that I would slap them. One girl I know was happy when I slapped her around. I guess I like that too. When I was a little girl, I remember my stepfather wanting to sleep with my mother; she didn't want to and he beat her up. He then chased me out of the house. I felt very guilty as if I had



been responsible for the whole thing. When I was a little girl, I was a tomboy and only enjoyed playing with boys. When they found out that I was a girl, they wouldn't have anything to do with me."

(Are you afraid of being a girl?)

"When I was 12 or 13 years old, my stepfather, as well as two of my uncles, seduced me and I lost all respect for them. One uncle, whom I had previously respected very much because he would tell me that sex was disgraceful and advised me not to have anything to do with boys, he goes ahead and seduces me. When I was in grade school, I had intercourse with one boy. This was the first time I ever had any relations. I became very frightened. I feared that I was pregnant. I worried for four months. I really did gain weight, but I guess it was due to eating too much. Whenever I'm unhappy, I eat a great deal."

This session again shows her attitude toward sexuality as existing on a sado-masochistic level; that it's the man who injures the woman, which always places her in a precarious position.

#### *Fourth Session*

"My girlfriends tell me not to trust you—that you are going to let me down—not to trust any man. At the dance the other day I was having a good time dancing with a girl when I saw the other girl I was interested in, who is going to get married soon, and I felt frightened and sick. Then some other girl told me that the marriage is off, but this information was wrong. My mother always left me for a man. She had several of them. I'll never forget one time she had a date and had no place to leave me. She took me along but warned me to say that I was her sister and not her daughter. Toward the end I forgot and called her, 'Mommie.' She got awfully angry. The man didn't see her again and my mother blamed me for breaking up this relationship. My mother always made me feel that she would have been happier if I had been a boy. She made me promise when I was about 10 years old that, when I grew up, I would take care of her. I told you that I had my hair cut like a boy when I was three years old. I just remember something happened about then. There was a red-headed girl about seven years of age who took me and a little boy in the barn and I know that something sexual happened, but I don't remember



exactly what; but I was very frightened. Shortly after that I cut my hair and wanted to wear boys' clothes.

"On the playground the other day I told one of the girls, 'I found out something new about myself. I enjoy being hurt.'" (Was that really the interpretation made last time?) "Well, you did say perhaps that I needed attention from my mother so badly that I wanted it even at the expense of being hurt. Its funny but I still get the feeling occasionally that I'm going to win my mother. I must still love her despite the way she treated me. Recently I stopped over in a place on Times Square and made a recording of the song, 'To The One Girl I Love,' and sent it to her. Yet, at times I hate her."

#### *Fifth Session*

"Some patient was telling me about Greenwich Village and how wonderful it is. She is a pretty sick woman. At times I like her but at other times I hate her. This time, when she talked so glowingly about Greenwich Village, I blew up."

*Dream:* "I had a technicolor dream about a mannish girl I know, not the one who is getting married. She had on a nice red shirt, pants and had lots of pretty girls around her. I had mixed feelings about her. I admire her and would have wanted to be in her boots. Yet I felt jealous of the other women and wanted her for myself."

*Associations:* Her associations with this dream dealt chiefly with her attitude toward her mother. "I resented her running around with men. At the dance Friday I danced with another girl, and I purposely went past the girl in the dream in order to make her jealous."

This session again shows the competitive feelings this patient has toward people seeking her mother's attention and affection, and brings forth another facet to her search for women as a means of making her mother jealous.

#### *Sixth Session*

"I had a dream. I think it was about you."

*Dream:* "I am working in a laundry. [She actually did work in the hospital laundry.] I'm at one end of the room and all the other women working there are at the other end of the room. Something seems to draw me to that other end. Perhaps I have to go



to the ladies' room. I go over there, go to the ladies' room and then start teasing one of the girls, pretending to feel her up and she becomes passionate. My common sense tells me to return to my end of the room to work, but after I get there, I change my mind and try to go back where the women are. A man tells me to go back where I belong. He uses force on me to keep me from the women. Something seems to strike me in the head and I want to kill him, yet I can't get myself to do it. I begin to scream. I wake up with anxiety and find that I was being awakened by an attendant for breakfast."

*Associations:* "The man in the dream reminds me of both my first and second stepfathers. Both were very cruel. They resented me even when I visited on occasions as a little girl. I also resented them because I felt that they kept me from my mother. Since I've started analysis with you, I've often wondered whether you are trying to force me to give up dressing like a man. I am all confused about men and women. I had a dream recently about a masculine girl here at the hospital to whom I'm attracted, but I like to tease her and get her angry. At times she appears to be like herself. At other times she is like my mother and then again like my husband. My husband is a neurotic, very attached to and dependent on his mother; yet he hates her. He loves my mother more. When I married him, he told me that he would like to be the woman in the family. He looks masculine though."

"Why is it I like to be hurt at times when I feel bitchy? The other day one of the women had an argument with me and she struck me across the face with a towel and I had a lot of pleasure out of it. When I was a little girl I was a tomboy and liked to play with the boys. They resented me and frequently beat me. I got a lot of pleasure out of that despite my anger. In recent years, with many women, I have actually provoked them to strike me. Do you suppose that this is due to a feeling of guilt that I have because of my hostility toward them?"

This session reveals her confused feelings regarding her sexual role and her difficulty in deciding which role to assume. This is also the first indication of any strong transference feelings involving the analyst. She expresses the strong desire to destroy anyone who wishes to place her in the role of a woman, which to her involves considerable danger.



*Seventh Session*

"I had three dreams last night."

*Dream 1:* "The masculine girl I like tells me she loves me, but my mother writes to me that she is sick and needs me. I leave the girl and go to my mother. I find that she lied to me and she wasn't sick at all. I get angry and leave her and go back to the girl."

*Dream 2:* "I go home to visit my little six-year-old sister, the six-year-old adopted sister. I'm very affectionate toward her. My mother comes up and starts nagging me. I feel she hates me and I begin to hate her terribly."

*Dream 3:* "I am dreaming of a masculine girl. I can't decide whether I like her better dressed as a man or as a woman. I decide I like her better as a woman."

*Associations:* "My mother was a terribly hostile individual. When I was a little girl, up to the age of 14 years, she used to lock me up in the house so that she could go to work all day. I had no chance to play with other children. A couple of times I broke out of the house and raised hell. I think I did that to get even with her. I was recently introduced to clitoral masturbation with considerable guilt. I get no satisfaction any other way. The only orgasms I've ever had with either a man or a woman, occurred when they put their tongues to my clitoris. Also when I have fantasies of masturbation or intercourse with women, they consist of clitorises touching. I am worried about my little sister. I would like her treated differently than I was, but I'm afraid my mother is making a neurotic out of her too. My biggest aim in therapy is to be able to live with a woman and have no anxiety about it. But now I'm so filled with hostility toward everyone that I can't live with any person, man or woman. To be a woman has always meant something terrible. All the men I've ever known have insulted and ridiculed women. I have disliked the manner in which men dominate women. I hate being dominated, even by women; yet at times I seem to enjoy it."

This session points out poignantly this patient's terrific and endless search for a mother, with persistently expected frustration as well as her feelings of vulnerability as a woman.

*Eighth Session*

"There was a patient out of the hospital with whom I fell in love and lived with. She is now back in the hospital in a very depressed



state, and I have considerable anxiety over it. I feel guilty over the fact that I may have been responsible for her return. It's funny that her nickname is 'Skippy,' and on several occasions I have called her 'Lucky' which is the name of another girl I like. All women seem to be the same to me. Some patient told me that 'Skippy' was going to get married. This upset me very much. I have insisted that she tell me, but she denies it. I feel greatly attracted to her. When we lived together, she was like a mother to me, but at other times I felt like the mother and she was my little girl."

*Dream:* "I'm back home in my mother's house lying in bed with her, in my second stepfather's bedroom. In the dream she has divorced him, which made her free to be with other men and I feel like a young fellow competing for her love. I have on boy's clothes. There is a sound at the door and she tells me to get out of bed because her third husband is coming. I feel very rejected. As I start going out, a young man comes in. He is violent looking, short, Spanish or Italian. I go to my room and start packing."

*Associations:* "This man who walked in looked like my husband, who was very attached to my mother and she to him. When I was a little girl, there was a sissified boy who visited my home, who liked my mother very much and she him. I didn't like him. She used to invite a lot of children into the house and wanted me to play with them, but I didn't want to. I had a weird feeling during the dream because, actually, when I was a little girl, she didn't let me sleep with her."

In this session her competitive feelings with people who, actually or in fantasy, attempt to take her mother from her are quite obvious. It is essential for her to be a man in order to gain the love of her mother.

#### *Ninth Session*

"I received a letter from my mother telling me that she is marrying her third husband. I've been quite upset about this. There's one particular girl on the ward with whom I have been having trouble. She prays a lot and reads the Bible constantly and then reads filthy stories. She must be a hypocrite. I can't be hypocritical. I want people to know just what's what. That's why I wear masculine clothes."

(Isn't that somewhat of a hypocritical act?)



"But if I wore dresses, that would be living an emotional lie."  
(Perhaps there are other factors involved?)

"I suppose by wearing a man's clothes, I am sticking my nose out for a punch; almost as if I were looking for ridicule and punishment and asking to be hurt. When I first began to menstruate, I asked my uncle, who was a prize fighter, to fight with me and not spare his punches. I wanted him to think of me as a man rather than a girl. He carried out my suggestion and beat the hell out of me."

Another facet of her transvestism is apparently her need to suffer. This psychic masochism demands that she be ridiculed and made to suffer. It is interesting that she chooses the onset of menstruation, which physiologically initiates her into femininity, to denounce her womanhood and to proclaim her masculinity.

### *Tenth Session*

"I have a very severe headache."

*Dream:* "A man and a women, both middle-aged, are coming out of church. They had just gotten married and both look irritable and neurotic. They decide to dodge everyone and go off by themselves in the mountains."

*Associations:* "What do you want me to tell you about the man? That he is you? I had a dream recently about my first stepfather of whom I knew very little, but in my mind he is associated with the 16-year-old boy whom I liked very much when I was 12. Although this boy was very nice to me, my aunt, with whom I was living at the time, objected to my seeing him. She told me that he had a bad reputation. Yet, she thought that this other boy, who was a homosexual and cruel to me, was alright for me to go with. This aunt was very mean to me. My uncle was all right, but she dominated him completely. It seems that I have always been subjected to sadistic people. My mother was very mean to me when I came back from the hospital last time. Also, my second stepfather wanted to have sexual relations with me, telling me it would clear up my nervous condition. He beat my mother a great deal. Is there such a thing as real love between people?"

(You have always professed the love of women and yet you keep describing women who have been mean to you.)

"I guess I really don't love them. I hate them. As a matter of fact, I can't remember a single woman with whom I had a close



contact whom I really loved; whom I didn't try to hurt. I liked my mother best when I could think of her as a little girl and dependent on me. Perhaps that has something to do with my wanting to be a man so I could take care of my mother."

In this dream, we have the first indication of any feeling of closeness to a man, with a fantasy of marriage to the analyst. We also get some indication of the meaning of homosexuality to this patient. It implies, not a love relationship, but one based on domination, control and hostility.

#### *Eleventh Session*

"I've been thinking about what I told you last time, that I hate women. I guess I really do. Every woman I've ever thought that I liked, I really wanted to hurt, but, why should one want to be with people one hates? Perhaps you have to be close to them to hurt them. I've been dreaming a lot since I last saw you, but I don't remember exactly what about. I think they are mostly sexual dreams of being raped by a man. [Up to this point the patient has been extremely ingratiating and polite toward the analyst.]"

(What is your attitude toward me?) "I know realistically that you are a very nice person. Yet I can't help but feel that you have a streak of nastiness underneath. You remind me a great deal of my second stepfather who frequently showed his mean streak. My uncle was a very nice fellow too. Yet, at every opportunity he made sexual advances toward me. One time he drove me out in the woods and tried to rape me. I guess I get suspicious when a man is nice to me."

This session indicates the patient's marked fear of injury by a man. Every relationship she has ever attempted with a man has ended disastrously for her. Her conception of a sexual relationship with a man is one fraught with danger and involves mastery of and rape by a man. Yet, a transference relationship is being developed with the analyst.

#### *Twelfth Session*

"I am very angry with one of the attendants on the ward. She is stupid, narrow-minded and thinks that we patients are that way because we have poor will power; that, if we only tried, we could get well."



(Why are you angry?) "She reminds me of my mother. One time, when I was a real little girl, I hurt my eye and she called the doctor. After he treated me, my mother told him she had no money to pay him. He became angry. She became very upset and bawled me out for getting hurt. No one has ever been kind to me. Even a psychiatrist at Bellevue Hospital told me one time that nothing could be done for me, that the only thing for me to do was to go to Greenwich Village and live with girls. The only man who ever showed any sort of kindness toward me was Louis, with whom I lived for a while. I have often wondered if there was something wrong with him to care for me. [Here there was a discussion of her low self-esteem, which is further borne out by the clothes she wears, indicating her low estimate of her role as a woman.] I guess you're right. It seems that I have always had a need to suffer. I need eyeglasses very badly; yet, when I get them I somehow manage to lose them or to destroy them. When I was a little girl, I complained about my eyes and my mother told me that I was imagining it. Later, when a definite diagnosis of hyperopia was made, my mother bought me some glasses, but I purposely broke them with the feeling that I was hurting her. One of the girls I lived with for a while, enjoyed beating me, but she told me that she also suffered by doing that. Whenever she beat me, I could tell that she was hurt and I therefore enjoyed it." (Here a discussion was entered into regarding masochism as introjected hostility.)

This session further develops the strongly ambivalent feeling about her mother, whose rejection and punishment she resents and yet expects and enjoys as a means of self-castigation. The role of psychic masochism as aggression comes out clearly.

### *Thirteenth Session*

"I always have headaches when I leave you. [Discussion of her feelings of hostility toward the analyst and her over-ingratiating manner as being a mask for this.] I think of you as being a threat, in a manner of speaking, because it is your intention to cure my neurosis so that I won't have homosexual feelings toward women. Somehow you produce the same feeling in me that my stepfather did in making me compete with him for my mother. There is an attendant whom I like very much who was going to get married, and shortly after the engagement party, they broke up. [The patient smiles while relating this.]



"You asked me why I smiled. Do you mean to imply that I am glad to see the marriage broken off? I guess I've always thought of a man as being a threat in taking some woman away from me, and I am therefore glad to see impending marriages crack up. In most cases when I loved women, they were either married or in some way involved with a man." (At this point her character resistance was gone into. Although she has been taking an intellectual part in the analysis, there has been very little emotional participation.)

"I guess I've always been that way. Even when I was a little girl. It was a sign of weakness to show any emotion. My mother used to punish me for every little thing that I did or didn't do, and it finally became necessary for me to be very secretive. It has always appeared to me that I would appear weak if I laughed and cried like other people do."

In this session, the negative transference involving the analyst becomes more evident as well as the driving need to take a woman-mother away from a man.

#### *Fourteenth Session*

(The analyst is wearing a pink tie.)

"Gee, that's some tie you have on, but it makes you appear sissified. [Discussion of her resentment of anything "sissified" or effeminate.] As a little girl I resented a boy whom my aunt wanted me to play with because he appeared to be a sissy. I preferred to play with rough boys and told them to be as rough as they wanted with me, and to forget that I'm a girl. When I was six years old, I played with a pretty, little, blonde girl, and in the game I always took the role of the husband, who worked as a butcher, and I resented very much when this little girl asked me to hold a doll because that would be sissified." (Discussion of her masculine clothes as also signifying the same attitude. She apparently considers the role of a woman unacceptable and to be avoided.)

"My mother always made me feel that to be a woman is bad. I remember her always telling me that she wanted a boy instead of a girl. My mother always went out with a lot of different men to bars to drink, and she took me with her. I resented these men a great deal because I felt they were preventing my mother from being with me more. I felt then that if I am to have my mother to myself, I have to be either as good or better than the men she went



out with. A couple of days ago I put on lipstick for the first time in my life. I asked another girl how she liked it, and she said she liked it very much. That was a great surprise to me because I always felt that girls liked me as a man rather than as a woman. Some of the girls, however, have been kidding me because, for the past two weeks, I have begun to let my hair grow long."

In this session, the patient continues to dwell upon her competitive feelings with men as a means of gaining her mother. However, some change appears to be developing in that she is beginning to experiment with the use of lipstick and letting her hair grow.

### *Fifteenth Session*

(The patient is under considerable tension today.)

"I hate all women. I have reached the point where I can't stand to have them around me. They annoy me, give me headaches. I feel like hurting them. I am very much attached to this married woman, and she shows me a great deal of love. I like her very much, but it frightens me. I told her to hate me. She is married but doesn't get along with her husband. [A discussion of her ambivalent feelings toward women.] I would like to have them love me, but I'm always afraid of being injured if I get too close to them. I felt that way with my mother. I also feel that way toward men. Take yourself, for instance. In your nice sort of a way, you are sadistic; for, don't you hurt people by confronting them with their problems? I look upon you as someone who is trying to force me to love people, and I don't think I am capable of it."

This session points out her strongly ambivalent feelings toward women as related to her experiences with her mother in childhood when every attempt on her part to form a warm, close relationship with her, resulted in frustration. She has built up a defense which involves the formula that close relationships are dangerous and should be avoided. The resistance to therapy is quite evident.

### *Sixteenth Session*

This session is characterized by marked resistance, long silences, and a generally irritable manner. She attributes her feelings to her emotional upheaval involving the married woman to whom she is rather attached. She cannot decide whether she loves her or hates her. The patient had begun to grow her hair with the intention of getting a permanent wave in the future, but when she



visited the hospital beauty parlor yesterday, one of the patient beauticians insisted that she looked better in short hair and proceeded to have her hair cut again, which procedure the patient did not seriously object to.

This session indicates the strong resistance which this patient is capable of bringing forth in defense of her neurotic structure.

### *Seventeenth Session*

"I am feeling much better today. My headaches are almost entirely gone. Lately my hostility toward women has almost overwhelmed me. The woman I am interested in was away for a few days and I was miserable. I am very much in love with her; yet, at times I hate her. The other day I was having a pleasant conversation with her when she got up and walked over to talk to one of the men. I was burned up. [Laughs.] I suppose you'll tell me that this means I am competing with men and think of them as taking the affection of women away from me. Well, maybe you're right. I really don't want the women sexually. I just want them to care for me. Sex has always been distasteful to me, either with men or women. I suppose my mother had a great deal to do with that. On a number of occasions I formed attachments with various women until they began to make sexual passes at me and then I began to hate them. There was a young girl at home whom I liked very much until she asked me to live with her and I became angry and left her. She later married and then I began to care for her again."

(You seem to be interested in women who are attached to men?)  
"Yes, I seem to be attracted to women with men. I have never felt guilty about hurting men. Most men I've ever known ridiculed girls and thought of them as being inferior."

*Dream:* "Doctor K. [on the hospital staff] is at my bed. He asks me if I am homesick and I answer, 'Not lately.'"

*Associations:* "As much as I have always hated my mother, I always go back to the home town at every opportunity. Lately I have been feeling more secure and thought that perhaps I wouldn't need my home as much. Perhaps there has been a change in me. I like this Dr. K. He seems to be a very nice, even-tempered person."

This session points out, not only her eternal search for a mother in every woman she meets, but also the utilization of this act as a



means of hurting the man from whom she takes the woman away. Further change is occurring, however. She is beginning to be more secure, and to show at least a partial capacity for displaying warmth toward a man.

### *Eighteenth Session*

"I've been feeling well all week. I'm very happy. There is a blonde patient on the ward with whom I've struck up a close friendship, but she is becoming very possessive and is trying to alienate me from my feelings toward the married woman. Whenever I begin to talk to the latter, she tells her things about me to make her jealous. I guess I'll have to drop the blonde. I just wrote my mother advising her that I want to break up with her."

(Why does that come up now?)

"I don't know—just that my mother always stood in my way of going out with girls. She told me that she would rather see me dead. I half suspect that she was jealous of my friendships with girls. Now that I think of it, when I was living at home, I frequently brought girls home and kissed them in front of my mother just to make her jealous, as if to say, 'You see you don't love me, but I can get others to do so.'"

(This, then, is another reason for your being attracted to girls, as a means of making your mother jealous?)

"I guess so. This blonde made me boiling mad the other day. She showed me a couple of 'hickeys' made by her husband just to make me jealous and she did. She wants me to come and live as a boarder with her, but I don't want to do that. I want to have her all to myself."

(It is quite true that in your relationships with women, you have been constantly seeking a mother. But no amount of fantasy will change the fact that you are not a man, but a woman.)

"Crazy people can do that. [Laughs.] I know I am a woman but I want to continue to act as a man. I'm reminded of the fact that when I was four years old, I was very much attracted to a little boy in the neighborhood, but my attitude toward him changed when my mother went out of the way to shower attention and affection on him in front of me, and made such remarks as wishing that I had been born a boy. My attitude toward him changed immediately and I began to hate him. Now I don't want to be a woman and I don't want to be changed. By the way, you told me that any



time I wanted to leave the hospital, you will let me do so. Does this offer still stand?"

(Her resistance to change was pointed out to her.)

This session shows a third reason for her choice of women as love objects. If the mother, a woman, does not love her, there are other women who do. Although the patient has shown considerable improvement up to this point and is under less tension, yet there is considerable resistance to further change, with emphasis on the fact that she does not wish to be changed to a woman.

### *Nineteenth Session*

"I have been having splitting headaches since yesterday. I think it involves this feeling I have toward the married woman. She told her husband she wants me to stay with her for a couple of weeks when I leave the hospital. I have the feeling that she is using me to hurt her husband. I don't like to be tied down. I want to be free. This has happened so many times to me before that I want to avoid it. Whenever I get too close to a woman, I begin to feel hemmed in. I also feel guilty in starting a marital rift."

(Yet you always seem to be attracted to married women. Perhaps that is what you want?)

"Yet, in fights between my mother and stepfather, I frequently took his part because I knew she was wrong in running around with men."

(Why the headaches?)

"I guess it's because I feel guilty about this affair I'm having. I suppose in a sense I'm hurting both her and her husband. Yet, I'm not hurting either. I don't cause problems between husband and wife. The trouble is already present before I come into the picture."

(There is a discussion of her cold exterior with little emotional display during the session.)

"I've always been that way. I was punished so many times for showing emotions as a child, that it was safer for me not to. When I went to the movies as a child, I just sat quietly by myself. I wouldn't even get up to go to the bathroom when necessary because I was afraid of criticism. Criticism was so banged into my head that it has apparently remained with me. There is something I have never told you. When I was 20 years old, I slept with a married woman while her husband was in the next room. The next



morning I decided to leave town and stole a bicycle which I sold to the husband for \$20. I felt very happy about it, but also guilty."

(Guilty?)

"I suppose I could have gotten him in trouble if he were caught with stolen property."

This session indicates at least a partial origin of her fear of displaying emotion, her fear of punishment by a mother figure. Also her competitive attitudes toward men in her struggle for the love of the woman—mother—is again apparent.

### *Twentieth Session*

"I don't know what to talk about. Sometimes I get the feeling you're sadistic. I don't know why. You certainly haven't acted that way. Maybe its my own feeling of wanting you to be sadistic."

(Why?)

"I've always picked sadistic girlfriends. This one girl wanted me to be mean to her. I purposely acted nice to her to get her angry. She would slap me around and I would laugh. That would make her blow up. It was my way of being cruel to her. With my mother, whenever she was cruel to me, I would do the same thing. I would act as if it didn't bother me and I felt that it hurt her more than if I would get angry and shout or cry. The woman to whom I am attracted is away and I feel better. I'm getting to feel that I shouldn't have anything to do with her because she is married and, since the explanation regarding my attraction to her has become clear to me, I don't feel very happy about being interested in her any more."

(Becomes quite embarrassed.)

"The last time I was waiting to see you, I had a fantasy that you were my father, and I liked the idea very much. Until I was 12 years of age, my mother kept telling me that my father was dead. I was satisfied with that explanation, but now that I know that he isn't dead, I've often wondered if I shouldn't look him up. Yet, I know that he wouldn't want to see me. He is married, and his wife probably doesn't even know about me."

*Dream:* "A very attractive blonde woman and I go to the barber shop in order that I may have my hair cut. The barber keeps me waiting and waiting, while he keeps talking to the fellows and, then, without paying any attention to me, he walks out with the fellows. I feel very angry. I think that he hates me."



*Associations:* "I've been growing my hair lately, and there has been conflict about it. Most of the girls I've known want me to be a boy and keep coaxing me to cut my hair. At home the barbers resented my coming to a men's barber shop and purposely gave me messy haircuts. Others just refused to give a girl a boy's haircut. The other day, while I was waiting to see you, you were busy seeing male patients. A feeling came over me that you cared more for them than you do for me. I felt the same way I did with my mother, when she kept giving me the impression that she wanted a boy instead of a girl."

(Discussion follows of the role of the analyst as the barber and her fear of being rejected by him. She admits that she has had misgivings about the analyst being nice to her, as no other man has ever shown any consideration for her.)

This is the first session to indicate any definite conflicts along Oedipal lines. To be sure, this is only a larval reaction, as it does not involve a full demand for the sexual love of the father and hostility toward the mother figure. There is, rather, an identification of the analyst with the mother figure, with the fear that even he favors the men in preference to her. Yet, it demonstrates a definite attempt to gain a father surrogate's love.

#### *Twenty-first Session*

"I blew my top last night with the married woman I like. We were preparing some coffee and a bite to eat, and, somehow, I was left out. I walked out in a huff and she came after me and tried to humor me. If there is anything I hate, it's that. I hate any sentimentality. It makes me appear as a weakling who needs someone's coddling. Suddenly she appeared like my mother to me and my anger welled up, and I began to bawl her out. My mother was like that. I never knew where I stood with her. Usually she did everything possible to hurt my feelings and yet when she felt that the townspeople were persecuting me, she would become very tender toward me. I didn't know whether I was coming or going. When I was with her, I was always wrong and made to feel that I wasn't wanted, and, yet, when at the age of 15 I left to live with my grandmother, she kept calling me frequently to come back."

*Dream:* "I'm walking all by myself on the street. Lou, the man I lived with, is walking along with a fellow and a girl. He walks



up to me and kisses me. I get all upset with myself because, on the one hand I like it, and yet I don't want to show that I do."

*Associations:* "I like Lou. At times he acted very effeminate and at other times like a man. I liked him better when he was a man. This other fellow I disliked because he was always trying to take Lou away from me. The girl in the dream, I don't recognize. I didn't like Lou when he wanted to be the girl and wanted me to be the man. My mother, too, was changeable that way. At times she treated me as if she wanted me to be a girl and at other times, a boy. The same thing goes for this married woman. At times she is very domineering and possessive. At other times she is very gentle. I don't like domineering, masculine women."

This session introduces some contradictory material. Although she has previously maintained that she wants to be a man, she now states that in her relationship with men, she wants the man to be masculine and she feminine. It is to be noted that even in her relationship with men, the prototype is the mother, who played a dual role as both a man and a woman, as at times she was very domineering and at other times gentle and feminine. The patient's confusion as to which sexual role she will assume is still a predominant factor in her thinking.

### *Twenty-second Session*

"I've been filled with hostility and headaches ever since seeing you, although I feel better now. I had a fight with a girl who had been saying mean things to me. This married woman, with whom I had formed a friendship, and I discussed our relationship as being unhealthy. I told her if I get well I will still be friendly with her, but not on a homosexual basis. I got a letter from my mother, signed, 'Love, Mother,' but all I can see is hate. My feelings toward her are all mixed up. It's a mixture of love, hate, pity, disgust. One time during the war, we were working together in a factory and she was flirting with some of the men there. I thought I would like to have her a little to myself. I invited her for a couple of drinks, and she started making love to a married man who was already in trouble because he had made a young girl pregnant. I burned up and I bawled him out, and he promised to stay away from her. When I was 17, I was living away from my mother and she invited me to visit her, but then tried to keep me there. She took me out to get me a drink and just to get even with her, I



drank too much. My usual way of taking out anger with her was to rush out of the house and dash madly down the street on my bicycle. I had five different bicycles and I would drive recklessly down the street. On one occasion I was trying to cross the street and a woman driver tried to make a turn. We both waited for the other. I got very angry and shot ahead and she did the same thing and she hit me. I wasn't hurt, but she was scared to death."

(Discussion of this incident brings out the fact that she could have prevented the accident as she had a feeling that the woman was going to start, but she was very angry with her.)

"I also drove a car once and hit my girlfriend. I swore I wouldn't drive again. These women here talk about their love for women and I keep telling them it is not love, that they really hate these women. I certainly see it in myself. They claim they don't love men; yet, I've always gotten along better with men than women. The women I have known have had a sadistic reaction. The more you hurt them, the better they like it. They like to be beaten up. I guess I do at times too. [Discussion of the love relationship as a constructive rather than a destructive force, and the significance of pathological jealousy.] My hair is still growing and I'm glad. The girls are making fun of me. They want me to cut it off."

In this session she continues to work out her sado-masochistic problems and is beginning to recognize that what she previously considered a homosexual love for women, was based on domination, possession and sadism.

### *Twenty-third Session*

"There is another woman who is getting friendly with me. I like her, but she wants me to be sadistic toward her. I also have crime on my mind, thoughts of stealing and getting arrested. What do you suppose this is due to? Is it that I want to be punished for something by being arrested? I know of people who seem purposely to get into trouble so they can be arrested. [This sounds very much like your situation with your mother when you were a little girl, when you wanted to be punished.] I used to want to be close to my mother, for her to love me, but I was afraid to show my feelings. It would have been a sign of weakness to show emotions. Somehow I had the feeling that if I showed emotions, I would be made a sucker out of."



*Dream:* "There is a fellow lying in bed, talking to a girl. I'm in the room and am very upset and I want to hurt someone and I make some nasty remark about him being engaged to me once."

*Associations:* "This fellow and I used to work together in a factory during the war. I liked him a great deal. However, he was sadistic. He used to throw knives at me as a joke, and once nicked my finger. My feelings were mixed about him. I hated him too. He used to embarrass me. We would go into a bar and he would order a glass of milk or a soft drink."

(Why should that embarrass you?)

"That was sissyish."

(You are always on guard against being considered a sissy. What would you do if you were really at a bar and wanted a soft drink?)

"I wouldn't do it. People would laugh and I would be hurt."

(You are afraid of being hurt? Is that why you don't show your true feelings?)

"I've always been that way. As soon as I start feeling soft for a person, I start changing in the opposite direction. In my family showing emotions was wrong. If my mother had only beaten me, it wouldn't have been so bad, but this constant nagging. That was hard to take."

(Apparently you had some tender feelings toward this man?)

"Yes, but I couldn't express my feelings because he was so mean. He looked something like you."

(What are your true feelings toward me?)

"I'm embarrassed to tell you, but I like you very much. Yet, when I start feeling this way, I say to myself, you must have a mean streak too, although I know that it is not true."

(You apparently don't show emotion because you fear it might result in injury to yourself. Your hard demeanor is only a defense.)

This session brings out a greater freedom in expressing tender feelings toward men, although with considerable trepidation about being injured in the process. Oedipal problems, which previously appeared to be practically lacking, now become more prominent.

#### *Twenty-fourth Session*

"I feel terrible. I hate myself because I have such hatred against the woman I thought I loved. She wants me to continue with her



and I want to break off the relationship. I am sadistic toward women who care for me and I like women who are sadistic toward me. I have a feeling that everyone on the ward is talking about our relationship. I don't want any sexual love from women. I just want to be near them. I don't like to continue the relationship with her because she is married and I'm sorry for her children. I've done some pretty terrible things in my life. I've slept with men for money and feel ashamed of myself."

*Dream:* "The police are chasing me because I did something wrong. I run to the house to hide and a boy and a girl there protect me. The girl starts playing up to me sexually. I am confused. I don't know whether I'm a boy or a girl. I don't trust her because I feel that she wants sex. I begin to talk to the man who is very nice, and my feelings toward him are more decent. I feel torn between them."

*Dream:* "I'm walking in a school yard, angry, passing other children, I'm confused about something. I return a book to the library and then walk to the wrong rooming house, but then I go back to the right one."

*Associations:* I don't trust women because they want sex from me which means that they want me to be the man. I know that I'm not a boy, that I never can be one; yet, I despise being a girl. Boys are so much more clean-cut and not catty. The boy in the dream was very nice. I've enjoyed relations with some nice boys. Most boys despise a woman they have had relations with. They talk about it. In the first rooming house in which I lived, there was an older man who was like a father to me, but he had something wrong with him. He didn't want women sexually."

(You felt safe with him?)

"You know who you remind me of—some storekeeper at home. I didn't like him. When I look back at the men in my family, I can see why I distrust men. Whenever I trusted them they tried to seduce me."

(Are you afraid I am going to seduce you?)

"No, I know you're sincere; yet, there is something in the way of my completely trusting you. My attitude toward women has always been rather peculiar, even as a little girl. I like to associate with attractive girls, even if they are mean to me. It made me



feel like a big shot to be recognized by these attractive girls; yet, with homely girls who openly showed their affection for me, I was sadistic. It seemed to play up my own feelings of inferiority."

This session demonstrates at least one facet of her feelings of guilt, and need for punishment as related to her hostile feelings toward women or mother, as well as her guilt over sexuality. Her relationship with the analyst has made her wonder whether her estimate of men in the past as being dangerous, has been justified.

### *Twenty-fifth Session*

"I'm working in the kitchen again and am very happy because I'm with the attendant I like. Yesterday I got through in the kitchen early and started on my way to the ward, but when I got to the door and knocked, no one answered. I knew the attendant was in the dining room and that I had to wait about one-half hour. I became very angry. It reminded me of the time when I was a little girl living with my aunt and uncle. They would go off to the movies and parties and I would have to wait at the door for hours in the cold winter until they came back. I had had a key, but lost it and for punishment they wouldn't give me another one. I'm still mixed up about my feelings toward women. These feelings vary between passion and hate. This attendant I like is rather sadistic toward me and yet I seem to enjoy it; yet, when I'm gentle toward her, I like to picture her as a sweet little girl and I'm the fellow. I used to picture my mother that way too, as an immature, childish person. In many ways I'm like my mother.

(Maybe you pictured yourself as a little girl in the way you would have liked to have been treated.)

"You mean the way I would have liked to have been treated by a man, my uncle? He was really a nice guy, but most men I've been attracted to have been mean and sadistic. Take the male attendants here, they have no respect for women. They make filthy, sexual cracks about them which makes me very angry."

(Why?)

"I wasn't raised that way. I guess to me sex has always been filthy."

(Discussion follows of her low opinion of herself because of her sexual drives—which explains her attraction to men who abuse her because she is not entitled to a nice man.)



*Dream:* "I'm riding in a car with people and we pass a huge building which seems to be a jail. I remarked that it looked like one of the hospitals I have been in."

*Associations:* "As I woke up, it occurred to me that the building looked like the Veterans Hospital that my uncle was in for a permanent disability resulting from World War I. He recently sent me a post card with a picture of the hospital. That same day the female attendant told me about her husband and little boy being injured in an automobile accident and had to be taken to the hospital for a short while. When I think of my uncle, I'm reminded that he was the only decent man I've ever known, just like a father to me. I frequently wanted to kiss him and be with him, but my aunt always got angry when I did that and threatened me. She was insanely jealous of him. In many ways he reminds me of you. You know, some of the attendants and patients have been discouraging me from coming to see you. They tell me to leave the hospital before it is too late."

(Like your aunt trying to keep you from your uncle?)

"In a way the building in the dream reminds me of this hospital. It's like a voluntary jail because I came here of my own accord. In the dream I had a happy feeling. I also felt frustrated. I wanted to come in there but something kept me from it. Maybe that's why I hate women because they keep me from men. My mother was very jealous of my attentions to my stepfather and, whenever I was angry with her, I would take my stepfather and go off for a few hours."

(By your anger and hatred, you actually expressed fear.)

"You mean, I'm really afraid of the women I hate?"

On leaving the analyst, after this session, the patient wishes him a Merry Christmas in a very friendly, tender manner, shakes hands and blushes. Asked why she blushes, she says that she is still embarrassed at showing any emotion.

This session brings out the patient's hostility and competitive feelings toward women as being actuated by their interference in her attempts to form a warm relationship with men. She responds to this by anger and with an attempt to take the man from the woman, resulting in feelings of guilt. Her self-hospitalization, therefore, assumes the character of punishment and repentance for her hostile feelings as well as for forbidden sexual aims. The



fact that she is now able to show a degree of warmth toward the analyst, is an indication that her fear of punishment by a forbidding mother is becoming considerably lessened.

*Twenty-sixth Session*

"I've decided on one thing quite definitely and that is that I can't live with a woman. They drive me whacky. They are so emotionally unstable, I don't know what to expect next."

*Dream:* "Skippy [a woman with whom she had previously had a love affair] is on a high building and I'm trying to reach her, but she is always beyond my reach. In the dream she hates me, but I'm trying to get her to love me. I get an airplane but still can't reach her. I feel very sick about it."

*Associations:* "Skippy was a patient I met here and although I was advised by the doctor against it, I continued to see her afterward. We had some drinks together and when she became upset again, and had to be returned to the hospital, I felt very guilty, as if I had been responsible for it. She is very much like my mother, very neurotic, and I never knew where I stood with her. At times I felt she hated me and I would get headaches as a result of this. I think what started the dream was that I was having an argument with the patient I had been attracted to, and I was very upset. She is very unpredictable and tries to dominate me, and I resent it. I developed a headache. In the dream, there seemed to be another woman with Skippy, but I don't know who it was. Somehow I have a feeling that my mother dominates the whole picture in the dream. My friends have been telling me to stop the analysis because they think I'm getting worse. Actually I think I'm a lot better, but they don't like the fact that they can't dominate me as much now as they used to, and there isn't as much need on my part for suffering."

In this session, the patient is beginning to recognize that she cannot be successful in the search for a mother by assuming neurotic relationships with women. There is also some recognition of the nature of her sado-masochistic attitudes toward women and her need for suffering has been lessened, though this is interpreted by her friends as unfavorable.

*Twenty-seventh Session*

(The patient is in a happy mood.) "I'm still working in the kitchen and like it very much. I ran into my girlfriend and the sudden thought came over me that she was my mother. She told



me I was getting worse and I should stop seeing you. By that she meant that I was standing up for my rights more now. When I asked why she thought I was worse, she laughed and said she really thought that I was better. I forgot to tell you that, during this last Christmas week, I dressed up as a girl one day, and I felt quite feminine, but I received so much teasing from attendants and patients that I took my dress off."

*Dream:* "I see my girlfriend and I love her very much. I become angry when her husband and another man, who was either her brother or her father, also pay attention to her."

*Associations:* "All I remember about the dream is of being alternately happy and angry over the situation."

(Discussion follows here of her feelings of competition with other men for the love of the mother.)

"My mother did have many men. It is peculiar that she tried to alienate me from all my friends and relatives. She always had something bad to say about all of them, but when I was with her, she wasn't very nice to me. She always kept telling me that I was going crazy."

We note an increasing ability on the part of the patient to express her feelings to the point of dressing like a woman and feeling happy over it. However, she still responds too readily to the criticism of other women, and to her need to gain their favor.

### *Twenty-eighth Session*

This session is punctuated by considerable resistance, irritability, complaint of headaches and hostility toward women. She emphasizes repeatedly that she does not wish to dress as a woman. When asked if she is afraid of being a woman, she responds that she cannot tolerate the criticism and the ridicule by others. She is willing to admit, however, that in many ways, she helps to create the situation which will result in ridicule. "I guess I have a need for punishment."

### *Twenty-ninth Session*

"I had two dreams last night, but I don't remember them too well except that they had to do with a man I lived with for a while. During the dreams I had the feeling that I loved him and would like to be with him. I am still very much attached to this girl, however, and that makes me very unhappy. She wants to give up her husband and be with me. One day I saw a man who was making a



play for her. He grabbed her impulsively and kissed her, and she seemed to respond. It made me sick. When I lived with the man I mentioned, I felt very insecure too. He was very effeminate and homosexual, but was very tender toward me; yet, I always wanted to hurt him, particularly when he insisted that I stay away from women. He wanted me to give up Greenwich Village. There was a man who was in love with my boyfriend who visited him regularly and brought him gifts. When my boyfriend responded to him, it made me very angry."

(There is discussion of the double identification. As a man her boyfriend wanted to take her away from women—mother. As a woman, however, he had other men attempting to take him away from the patient.)

"I seemed to enjoy hurting him, just as I would\* have enjoyed having him hurt me, but which he never did. No matter what I did, he responded with kindness. Even as a little girl I enjoyed being hurt. I got pleasure out of being beaten up by boys. I had a dog I enjoyed hurting."

(Discussion follows of the basis for her masochism.)

"I had a feeling that if I am hurt, my mother would pay more attention to me. I used to want to hurt my mother. I guess it was a form of rebellion. I created a reputation in town of being a drunkard, although I drank very little, and my mother used to say to me that I was disgracing her.

"Some of the girls want me to grow my hair; others want me to cut it off. I don't know how I feel. Sometimes I feel like cutting it off. One thing I am sure of is that I don't want to be a girl."

(Is that what you really mean?)

"Maybe I'm afraid of being a girl."

The various facets of her masochism come out in this session, among them being masochism as a means of punishing her mother, also a means of punishing herself, because of guilt.

### *Thirtieth Session*

*Dream:* "My mother comes to take me out of the hospital. I have a talk with her and she seems all right. I'm not afraid of her. Suddenly she begins to hallucinate and I become frightened and refuse to go with her. She forces me out of the building, but I run back in again. I prefer to be in the hospital. All along I am worried about two suitcases I had packed and couldn't find, and am



afraid that someone may have stolen them. I wake up with a splitting headache."

*Associations:* "I received a letter from my mother which was pretty nice, but she accused me of lying to her when I told her I hadn't received stationery from her. I had also inquired about my little brother and she wrote not to worry about him, that, if any other two children had received as much care and attention as we had, they would be more appreciative and would show more respect and love for their mother. Before I began my analysis, I would have felt very guilty after such a letter, but now I was more thoroughly convinced of my mother's maladjustment. She never gave me the thing I really wanted—affection. Sure, she gave me material things which made very little difference to me. I'm worried about this girlfriend of mine. I think she is cracking up. I told her the other day that she is like my mother. At times she acts very friendly toward me and suddenly she becomes very unreasonable. The other day I tried to kiss her and she drew away as if she were afraid of me or didn't like me. She has been asking me to leave the hospital and go to live with her, but, because of her emotional state, I can't make up my mind. The fellow, who has been playing up to her, seems to upset her. She has also had trouble with her husband."

(You seem to resent both the husband and the other man.)

"My mother used to sleep with various men and I felt left out of things. She would make me sleep on the couch if she had a man with her."

(Attempts to disclose her associations to the packed suitcases only yielded the fact that she kept her belongings in two packed suitcases. The sexual significance was not forthcoming.)

"You notice that my hair is growing quite long. I can't decide whether to cut it off or make it up in a feminine way. I'm not quite ready for that, I guess."

This session shows a significant change in her attitude toward her mother; whereas, previously, she felt guilty over her unconscious hostility toward her mother and responded to this by masochistic behavior, she now is beginning to recognize the mother's own emotional instability and neurotic needs. One can conjecture the meaning behind her dreaming that her suitcases are packed, ready for a trip, and yet that she is not quite ready to take it.



*Thirty-first Session*

This session is punctuated by considerable resistance, the patient's manner is distant, and her productivity is diminished.

*Dream:* "I spend the night at your house as a friend. Next morning you come down the stairs and kiss your wife and children affectionately. I watch and try to figure out whether you really love them or have hatred toward them. My mind plays tricks on me. You and I get into your car and you tell me that I should get my hair cut and then you would take me to another state to see other doctors. I'm hoping there might be a chance of being turned into a boy physically. I want to get a job as a tree-cutter in the woods. I go over to see a girl about it. She drives a truck hauling logs to the mill. I envy her. She reminds me of a homosexual girl cab driver I knew in Greenwich Village. The woods remind me of my stepfather and I hauling logs to the mill, which I enjoyed doing very much."

*Associations:* "I cut my hair again. All I want in treatment is to clear me of my headaches. I don't want to be changed into a girl. The cutting of hair and trees in the dream may have something to do with my wanting to cut treatment. I belong in Greenwich Village. Before I started treatment, I had lots of guilt about my sadism toward other girls and I suffered over it. Since I began treatment, I've begun to realize that they enjoy my hostility as much as I do. It's therefore a mutual thing."

(Why your sudden change in attitude since you last saw me?)

"I feel hostile toward you. I don't know why. You've been quite wonderful and everyone likes you. It must be that I have no capacity for loving anyone. In the dream I had the feeling that I would want you as a father, but only if I could be a boy. When I worked with my stepfather at logging, I had a wonderful time and felt that I was on an equal level with him, but, as soon as he began to make sexual advances toward me, I became very angry and threatened to cut him up with a knife. When I go to Greenwich Village, I want to look enough like a girl so that homosexual men would leave me alone, and enough like a boy so that homosexual women would be attracted to me."

(In the dream you stand off a distance watching me show tenderness toward my family.)

"I didn't care. I had no feeling about it."



(Afraid to show your feelings?)

"I've always been that way."

This new resistance was precipitated by the fact that the patient saw the analyst driving his car with his family. She became very upset and, immediately thereafter, had her hair cut again.

### *Thirty-second Session*

"I suppose you wonder why I had my hair cut. I just like it that way, so why shouldn't I have it?"

(You say it as if you were in rebellion against someone?)

"My girlfriend wanted me to grow my hair, and she'll probably be angry."

(Why do you rebel against her?)

"She wants me as a girl so she can dominate me; yet, she lets this married man show attention to her. He's a real rugged guy with hair on his chest. There is nothing sissyish about him."

*Dream:* "I'm in my home town walking along with my girlfriend on the way to the movies. A man comes along and starts talking to her. She seems to have a crush on him and is happy. I'm hurt and walk away by myself. The neighbors are watching, and, in my resentment, I tear off my tie and put it in my pocket and want to go off and steal something."

*Associations:* "This girlfriend is like my mother. She has lots of men and likes to hurt my feelings. I'm also reminded of my aunt whom I loved very much. Some man liked her, but she paid no attention to him, and he followed us to the movies. He finally made her pregnant and she married him. I've always thought of neckties as being sissyish. I like men who are rugged and don't wear neckties. I gave all my neckties away. To me, stealing is also a sign of being rugged and manly, like the gangster type."

(A discussion of her resistance against treatment and cutting her hair off as a rebellion against the analyst.)

"I feel more attached to doctors who have some problems of their own, because I have problems and they understand me better." (This is obviously a resistance to treatment, since you cannot be helped by people who have serious problems of their own.)

The patient is still reacting with hostility toward men who, in her fantasy, take her mother away from her. Her defense against



this is to be as rugged as any of them. In her relationship to the analyst, she is building guards against the recently developed tender feelings toward him, which, to her, represent a threat.

### *Thirty-third Session*

"I'm all upset about my girlfriend and that man who is paying attention to her. She seems to be falling for him. I will have to give her up. What makes me angry is the fact that she is a married woman, and I can't stand a woman who is unfaithful."

(Is that what upset you or is it the fact that you feel left out?)

"I feel jealous. I had similar feelings with my mother and her men friends."

*Dream:* "Two patients are having a fight, and they curse each other. They are supposed to be good friends. I feel sick and angry about it. I blow my top and begin to scream at them, and tell them that, if they don't stop fighting with each other, I'll bang their heads together. I feel like killing. I wake up with a terrible headache."

*Associations:* "Before I met my girlfriend, I was friendly with one of the girls in the dream who is quite feminine. This girl then became friendly with this second girl in the dream who is quite masculine. Now they are really on the outs and argue a great deal. I hate to see them unfriendly toward each other." (Do you really?) "Maybe I'm jealous and would like to be back with this girl."

(A discussion of the meaning of her headaches follows—and her realization that hostile wishes coming true, even in fantasy, have something to do with them.) "I've been brought up to feel that even thinking mean thoughts is bad. When I was a little girl, I felt guilty over asking to be loved by my mother when she had so many men to love. It was as if I did wrong in feeling that way, as if I wasn't entitled to her love as much as they were, and that she couldn't love both them and me at the same time."

(There was interpretation of her psychic masochism as being based on the premise, "I am wrong in wanting or receiving mother's love. Therefore, I should be punished.")

### *Thirty-fourth Session*

"What do you think of Ingrid Bergman?" (She is referring to the recent marriage of the actress to a man who had divorced his wife.) "I hate some of the attendants who criticize her behavior."



(Do you identify yourself with the actress?) "No, I identify myself with Rosselini, who was in the position of taking a married woman away from her husband. This girlfriend of mine has another man making up to her. I'm all upset about the situation. I recognize the fact that it was a similar situation with my mother. I tell this girl that she reminds me of my mother. My mother had various men and when she consorted with them, I felt completely left out. At times I pictured myself as a young man courting her, and she seemed to enjoy that relationship. She hurt me terribly by having men friends in front of me, and I would anger her by telling her of my girlfriends. I told my girlfriend that I recognize that our relationship is an abnormal one, and that I'm looking forward to meeting a non-neurotic man. She gets angry when I tell her that. I think she resents you very much."

The patient apparently continues to identify herself with men and is using the analyst as a means of making her girlfriend jealous so as to remain in competition with other men. Here, then the analyst is identified with a woman—her mother.

#### *Thirty-fifth Session*

"I blew my top and still have headaches over something that happened. My girlfriend actually had a sexual affair with the married man, and she told me about it. I became very angry with her." (Why?) "Because she has a family to think of." (Is that all?) "I guess I was jealous. I felt that I couldn't trust her. I don't like to be taken for a ride. She told me a dream she had which I interpreted as meaning that she is afraid that I want a man instead of a woman."

The last statement about wanting a man instead of a woman has to be analyzed in context. It appears to represent, not a wish, but another means of controlling her girlfriend.

#### *Thirty-sixth Session*

*Dream:* "I steal some bicycles and try to sell them in another city."

*Associations:* "As a child, when I was angry with my mother, I went riding on my bicycle. That was the only escape for my anger. I felt reckless and could control almost anything by the speed with which I rode."

*Dream:* "I'm going to a movie and am accosted by three drunken men who want to rape me. I have a gun which I know is not loaded,



but I try to scare them by pulling the trigger, but no bullets come out. I then hit them on the head with the muzzle. A policewoman comes around and wants to search me. I become panicky because she'll find out that I'm not a man. Then this homosexual girl, who dresses in masculine clothes, and whom I dislike, comes around and this time she is dressed as a woman. She is quite effeminate, and she lets me kiss her on the neck."

*Associations:* "I'm reminded of my three stepfathers who I felt stood in my way of being with my mother. I used to use them, however, when I wanted to make my mother jealous. Each of these stepfathers had made sexual advances toward me, at one time or another. The other day I was wrestling for fun with this girl I like. She is very strong, but I finally won. I momentarily felt very hateful to her, and blacked out. This used to happen with my mother. Every time I had a fight with her and felt like killing her, I would have a fainting spell. As a little girl, I had the feeling that my mother liked me better as a boy. Whenever she wanted to hurt me, she would start fooling around with men in front of me and I could get her angry by fooling around with girls."

The patient is beginning to realize that the fantasy of her masculinity is only a pose. As she expresses it, "I have a gun which I know is not loaded." Yet, that pose is still necessary for her in her competition with men for the love of the mother, as well as to please the mother who, in her fantasy, wants a boy rather than a girl.

### *Thirty-seventh Session*

*Dream:* "There's a young fellow I like until he steals my bicycle. I feel hurt. I insist that he return it at once. We start a search for it. Then the bicycle becomes a dog and we are looking for a certain dog. We find a good many of them, but I refuse them. I want only a certain one. In the end I find it and am very happy."

*Associations:* "Bicycles and dogs have always been very important to me, since my childhood. There was one fellow I was very fond of when I was about eight years old. He refused to let me use his bicycle and I stole it for a ride."

*Dream:* "I'm in a place which looks like a Catholic home with a group of young girls. Everyone is going to church for confession. I feel confused. You come into the room to eat your breakfast and,



after a while, I tell the other girls to go to church without me because I don't belong to a church anymore."

*Associations:* "I've turned against my religion. I somehow associate the church with everything bad that ever happened to me. The fact that you came down for breakfast would indicate that you lived in the same house as I did." (She blushes, and states that she is very embarrassed.)

*Dream:* "I have a good understanding mother. I'm very fond of her. I'm back in my home town wearing a plaid skirt instead of pants. No one is making fun of me, but I feel quite shaky."

*Associations:* "I met an older woman here who is like a kindly mother to me. She does things for me and I feel very relaxed in her presence. Ordinarily, I have a feeling that other women do not wish me to be a woman. In Greenwich Village, there was one blonde woman who became angry with me once when I even suggested wearing a skirt, but this woman makes me feel that it is worthwhile being a woman."

*Dream:* "I'm being psychoanalyzed when the girl I'm attached to rushes into the room and wants to talk to you about her own personal problems. You tell her to wait and then she notices me and is quite surprised."

*Associations:* "This girlfriend is actually very much opposed to my seeing you. She feels that you will wean me away from her."

There are elements in this session to indicate that the patient is beginning to differentiate between neurotic and healthier women. She even finds herself wearing a skirt without too much anxiety and can contemplate a relationship where the analyst lives in the same home with her and comes down for breakfast.

### *Thirty-eighth Session*

*Dream:* "I'm trying to reach a normal life. I can see it ahead of me, but things seem to get in my way. I want to be honest, but people prevent me from being that way. I wake up very angry."

*Associations:* "I woke up from the dream feeling quite free, but empty inside. I've been quite hostile toward my girlfriend because of the affairs she has been having with the married man. She came to me and told me that she really didn't have an affair, but was only trying to make me jealous. I've definitely decided, however, that I wasn't going to get too involved with her any more."



(Discussion follows of her fear of getting hurt in her relationship with women.)

"Somehow I have the feeling that all women are hateful. I've become like a hermit since seeing you because I can't stand neurotic women any more. There are two friendly, well-adjusted attendants who make me feel secure. There isn't that jealousy and struggle as with other women. When I'm with them, it makes no difference to me whether they like others also, because there is no limit to their love. The neurotic women give me headaches and stand in my way of getting better. In the dream I could picture myself as a girl, but there were obstacles in the way."

In this session the patient works through a situation which undoubtedly existed in her relationship with her mother, to the effect that it is dangerous to get emotionally close to a woman because of the possibility of being hurt. Also, that sibling rivalry is only an indication of the mother's inability to love; for, the non-neurotic individual has a boundless capacity for loving. "There is enough for everyone."

\* \* \*

From here on, only the significant sessions will be recorded.

#### *Forty-second Session*

*Dream:* "I'm arguing with a man I hate. He is scheming to get my job. I am boiling mad and want to beat him up. He begins to talk to my boss in front of me and I don't trust him. I get a splitting headache and go for his throat. I want to kill him. I wake up with a bad headache."

*Associations:* "You notice I'm dressed in men's clothes again. I think it's all due to this girlfriend of mine. I hadn't seen her for 16 days and now she is back again. I felt better when she was away. Now I am anxious again."

Her strong need for masculinity is quite apparent in this session. After experimenting with feminine attire for a time, she suddenly gives it up because of her relationship with her girlfriend, with the feeling that, in order to gain her friend's love, she must be a man.

#### *Fifty-second Session*

*Dream:* "My mother is mentally sick and she is put in a hospital. She looks quite confused, lost, lonely, and like a little helpless child. I want to take care of her, but she is in a fog, and



doesn't know me. I wake up in the middle of the night crying a little."

*Associations:* "My feelings toward my mother have changed considerably in recent weeks. I always felt that I hated her; that, she didn't give me a break in life. However, I am beginning to see her now as an unstable individual who had her own emotional problems and that, when she treated me badly, she could not help herself. I wish I could be in a position to help her now, but I'm so sick myself that I can hardly help myself."

The recognition by the patient that her mother's rejection of her in childhood was influenced by the mother's neurotic attitudes is a step forward. As she admits in the dream, however, although her mother needs help, the dependency need on the part of the patient is so great that she cannot see herself breaking the neurotic ties to her mother.

#### *Sixtieth Session*

*Dream:* "A girl is trying to fire a gun. She keeps pulling at the trigger, but nothing happens. I keep telling her to load the gun, but she won't listen. I become angry at her stupidity. I tell her that it will never shoot until it's loaded. I take the rifle from her, load it, and she fires it. I'm satisfied."

*Associations:* "I used to have a gun and always used it in shooting at targets. The girl in the dream resembled my mother. Although my mother frequently gave the impression of being effeminate, yet, she seemed to be in competition with her husbands as well as with other men. For instance, she would shingle a roof by herself. I can't help but think that a gun represents power, and if a woman uses a gun, it puts her on an equal basis with a man. Its like having a penis."

The drive for masculinity continues. She identifies herself here with the mother in her competitive feelings with men.

#### *Seventy-first Session*

*Dream:* "I'm sleeping on a small couch. I feel danger and open my eyes. A tall, madman is looking down at me. I know he wants to kill me. As he grabs for my throat, I escape. I stay with a few girlfriends and feel safer with them."

*Associations:* "This dream reminds me of the time I was living with my aunt. She walked in her sleep and on several occasions,



she tried to choke me. She apparently hated me. Also when I was a little girl living with my grandparents, my grandfather became psychotic, and, even after he died, I had nightmares of his coming to my bed to choke me. The man in the dream reminds me a great deal of you. I'm still a little afraid of whether you may hurt me, although, realistically, I know you're helping me."

The patient is attempting to work through her competitive feelings toward men through the analyst. Her life is dominated by a fear of injury by men, who took her mother away from her, or by masculine women, such as mother, who denied her love.

#### *Eightieth Session*

*Dream:* "M. and her husband are living in a cottage away from all people. I go there to visit and she seems to be in the background and I am admiring her husband. I feel guilty, but I can't understand what my real feelings are."

*Associations:* "I liked this woman's husband a great deal, but I was afraid to show it because she was very jealous. Despite the fact that my stepfather treated me as badly as he did, I still liked him in some ways, but I was afraid of what my mother would do to me. The same situation existed with my uncle and aunt."

The patient's previous protestations that she did not care for men, that she resented them because they took her mother away from her, are apparently not entirely factual. Oedipal conflicts are more definitive now than ever before. Her need to take a man away from a woman, but fear of the woman's retaliation, play a role in this dream.

#### *Eighty-seventh Session*

The patient is beginning to express a strong desire to leave the hospital and try to adjust herself in the community. She will be leaving within the next few days.

*Dream:* "I'm trying to find a man's suit, but I can't get one. I'm angry and upset. I'm having sex relations with a young girl back home. I'm not satisfied because she is not passionate. I'm walking up the street toward my mother's home. All the trees are down and seem to block my way."

After these many analytical sessions, the patient still finds herself perplexed at the difficulty of finding her mother unless she is a man. She intends to leave the hospital as a girl, but is very uncertain about the future.



The patient did leave the hospital, obtained employment in a factory and seemed to be making a satisfactory adjustment. She became acquainted with a neurotic man, and went with him to various places of amusement. She felt relatively secure with him until he began to make sexual advances toward her, and she then broke off the relationship.

*Ninety-fourth Session*

*Dream:* "A snake is attaching itself to my hands. I'm scared and try to get free from it. I hold its head away from me. Finally get tired of fighting and assume a devil-may-care attitude. I then find that I'm not so frightened, but, yet, feel sick inside thinking of it."

The patient has shown some progress in that she has been able to form some sort of a social relationship with a man. However, she still cannot tolerate sexual attitudes on the part of a man, as they indicate something frightening and dangerous. It is significant that shortly after this incident with the man, she again changed to masculine clothing and cut her hair short.

*One Hundred-fifteenth Session*

*Dream:* "My uncle is in a big parade. He tells me he left his car parked down the street and, after the parade, he wants me to take it and drive away. I'm happy over that. When I go to get it, I find my husband stealing it from me. I get boiling mad and run cursing after him. I finally catch up with him and have him cornered when he turns into a cat and I become sick to my stomach when the cat blows up and the guts spray all over me."

This dream occurred while the patient was continuing to make an effort to adjust herself outside the hospital. She was going out occasionally with men, but avoided sexual relations. She was struggling between her attitudes toward the good and bad men in her fantasy. The uncle represents the good man and, in fact, was the most favorable influence in her childhood. Her husband, on the other hand, represents the weak, therefore effeminate, man, who, like mother or cat, represents a constant source of danger and destruction.

*One Hundred Twentieth Session*

*Dream:* "I'm watching a train go by. Something large falls at my feet. It smashes open and gallons of oil fill the air. I run be-



cause I think that there may be a fire or an explosion. The oil soaks me so I take shelter where there are men working. I feel lonely and buy some food from a woman at a lunch counter. She is middle-aged and quiet."

*Associations:* "I am working at a factory with mostly girls. However, the boss is a man. He has been very nice to me, but I don't trust him. He hasn't made any sexual advances toward me, but the other day we were watching a parade from the factory window, with General MacArthur and his son, and he remarked to me jokingly that I could go for the general. This made me very angry and the same day I had my hair cut again. I feel so much more secure working only with women."

*Dream:* "I'm in a house with women and babies. There is an earthquake. This seems to be the end of all life. We are arguing which room to stay in. I want the strongest room available. I also want to be near a woman to love, but I can't quite reach her. It makes me feel lonely and anxious."

In this session the patient is continuing to make an effort to adjust as a woman, but is constantly threatened by the implication of sexuality offered by men, still considers them a threat, and wants to escape to the security of mother.

### *One Hundred Thirtieth Session*

*Dream:* "The hood of a car is lifted and three men are trying to fix something inside. The world is full of bitterness and distrust. I want to trust one of the three men, who seems to be you, but the other two are very hostile. In the dream you are cheerful and friendly. I would like to be emotionally attracted to you, but instead I am attracted to other men."

This dream occurred while the patient was going out with a neurotic man who was rather sadistic toward her. Despite the fact that she intellectually recognizes the sado-masochistic character of her relationships with men, she finds it necessary to continue such relationships.

*Dream:* "I'm back home with my aunt and uncle. We are in a hotel room. I have a headache and feel very angry and scream at them, then run out into the street. I want to get in some kind of trouble. I see some bad men who tempt me, but I go to some girls instead. I feel all mixed up."



This is the aunt who was extremely jealous of any attention paid to the patient by the uncle so that the situation created was not only that of a competitive feeling against the man in her relationship to the woman, but also a reaction closely resembling an Oedipal situation, in which she resented the uncle in her attempt to gain the aunt.

*Dream:* "I feel quite peaceful until my mother comes in. We are both lying in bed. She looks at me in an angry fashion and yells, 'Why won't you love me?' I reply, 'I don't know what love is.' She becomes violent, grabs my arm and throat, wants to kill me. I become frightened and escape."

This session again emphasizes the ambivalent feelings the patient has toward her mother—feelings which have as yet not become resolved.

The patient continued visiting the analyst during her stay out of the hospital. After about five months she lost her position because there was insufficient work there, found it increasingly difficult to find employment and was forced to receive public welfare assistance. During this period, she formed a close relationship with another girl which was punctuated by repeated and frequent arguments, recriminations, and threats to break up. Although the patient found a great emotional need for the relationship, she recognized that there was little real love involved. During this period also, she continued to wear feminine clothing with some sensitivity. There was not the compulsive need to form new relationships with women that she previously had. Yet she felt helpless and impotent in forming close relationships with either women or men.

\* \* \*

After 10 months out of the hospital, she voluntarily returned herself.

#### *One Hundred Fifty-fourth Session*

*Dream:* "A fellow has a snake in his hand and points it at my face as if wanting to bite me. Before that I had friendly feelings toward him, but now I have become angry and developed a headache."

*Associations:* "I had a feeling in the dream that the fellow was threatening me with sex. So many men take advantage of their superior strength and their sex to insult and hurt women. There



was a male employee in the dining room where I worked whom I liked very much, but he always boasted of his affairs with women, and I had the feeling that he really did not love women, but wanted to see how many he could hurt."

In this session the patient shows a friendly attitude toward men, but is threatened by them when they show any sexual interest in her. To her, the sexual act is an enslavement of the woman by the man and, therefore, must be avoided.

\* \* \*

This, then, is the patient's condition at the present time. She finds the environment of the hospital protective in the sense that it offers a permissive family unit and still avoids the formation of too close or too lasting emotional relationships. She wears dresses and long hair, uses lipstick, and enjoys going to dances, although, up to this day, she has not danced with a man. She has verbalized her fear of the outside as requiring an independent existence, whereas she wants to be protected and supported by a mother substitute, that is, the hospital. However, she has not entirely closed the door on future development as she is again talking in terms of leaving the hospital in the near future and attempting to find employment. It may seem paradoxical that, in the one important limitation that she placed on analytic therapy, that is, that she not be changed to wear feminine clothes, improvement has occurred, whereas, in other spheres, the progress has not been too marked.

#### DISCUSSION

This case presents a number of important considerations, not only on the subject of transvestism, but on the whole sphere of feminine psychology with its component fields of the pre-Oedipal and Oedipal phases, sado-masochism, homosexuality and many other related problems. A study of the history of this case brings out a close relationship between her insatiable drive for masculinity and her early relationship to her mother or mother substitutes. Men have played a relatively unimportant role in the formative years of this girl's life, except in situations of actual or fantasied competition. She became convinced quite early in life that a woman's role is disadvantageous and dangerous. Wasn't her mother made to suffer by a man, by being forced to have an illegitimate child, the patient? In the mother's numerous relationships with men, it was quite obvious to the little girl that a state of war



existed between the man and the woman, and it became a question as to who would dominate whom.

The mother took care to point out to her that the situation would have been much different had the patient been born a boy instead of a girl; that she could depend economically more on a boy than on a girl in later life. Being shifted from one home situation to another, all unfavorable, was quite convincing to the child that she was not wanted. She saw herself neglected by the mother for various men, which was sufficient proof for her that, in order to obtain her mother's love, she had to be a boy. Her emotional attitudes toward her mother have always been ambivalent. On the one hand, she wanted the love of her mother, and did everything possible to obtain it; on the other hand, because of past experience, she expected constant repulsion and reacted to it with hostility and rage.

Equally ambivalent have been her feelings toward men. On the one hand, she wanted the love and protection of a father figure, such as her uncle; yet, her experiences proved to her that the man is not to be depended upon, that he utilizes every display of tenderness on the part of the woman as a means of seduction and destruction, as was actually the case with her stepfathers and uncle. Furthermore, there was always a hostile mother figure to prevent her from getting too close to a man. In a compulsively repetitive manner, she started early in life to compete with men for the love of the mother, even to assuming a man's attire. She wanted to love and take care of a woman in the way that she would have preferred to have her mother behave toward her; but, because of her ambivalent feelings toward the mother, her relationship with all women had to be on a sado-masochistic level; that is, in every relationship between a man and a woman, it is always the woman who is in a precarious position. Added to the masochistic quality of her emotional life, is her feeling of guilt that she was responsible for her mother's unhappy situation, and should be punished for having hostile feelings toward her. There are reasons to believe that even the act of wearing men's clothing has a masochistic quality behind it, and, as she expressed it, "I am sticking my nose out for a punch, almost as if I were looking for ridicule and punishment and asking to be hurt." She also employs suffering as a cudgel over her mother. "My suffering hurts my mother more than it does me."



Freud, in his early writings, stressed the Oedipus complex as the core of the neurosis. It was not until late in life that he began to realize that a more important phase than the Oedipus phase, particularly in women, was a pre-Oedipal stage in which the primary attachment on the part of the child is to the mother, in the case of both sexes. In fact, he later stated,<sup>7</sup> "Many a woman may remain arrested at the original mother attachment and never properly achieve the change-over to men." He later also makes the significant statement that, "We shall have to retract the universality of the dictum that the Oedipus complex is the nucleus of neurosis." He properly gives credit for this new development in the psychology of women to women analysts, for they were "able to apprehend the facts with greater ease and clearness because they had the advantage of being suitable mother substitutes in the transference situation with the patients whom they were studying." This early relationship of the child with the mother is based chiefly on the child's need for support, security, food and protection, and, only indirectly, involves any erotic feelings on the part of the child for the mother. Even any outer manifestation of erotism is perhaps only a symbolization of the child's need for the closeness and the protection of the mother. It is this utter dependence of the child on the mother, in the early period of life, and the child's subsequent reaction against such dependence which creates a neurotic impasse. On the one hand, the child wants to depend completely on the mother and live in the eternal Nirvana of the intra-uterine state. On the other hand, it reacts with rage and resentment against such dependency. Such conflicts can become totally overwhelming in situations where the mother, because of her own neurotic needs, makes progressive and normal maturing on the part of the child difficult or impossible.

Brunswick,<sup>8</sup> in her discussion of pre-Oedipal influences upon later femininity, states, "The remarkable aspect of this case (a paranoid woman) is the total absence of the normal oedipus complex. The traumatic seduction had so fixed the patient to her first homosexual love object, that all further development was blocked. The poverty of psychic growth produced a simple, childlike individual in whom pre-oedipal attitudes and mechanisms, normally over-shadowed by the complications of the oedipus complex, were outstanding."



A study of the present case indicates that here, too, pre-Oedipal factors play a very important role and that the Oedipus complex is either absent, or present in only an incomplete state. The author is of the opinion that a similar situation exists in the analysis of a great many women, particularly in very dependent, passive, immature individuals, as well as in schizoid and schizophrenic subjects.

The question comes up as to the relationship of female transvestism to homosexuality. This would depend a great deal on our concept of homosexuality.

Kinsey<sup>9</sup> states, "In view of the data which we now have on the incidence and frequency of the homosexual and, in particular, on its co-existence with the heterosexual in the lives of a considerable portion of the male population, it is difficult to maintain the view that psycho-sexual reactions between individuals of the same sex are rare, and therefore abnormal or unnatural, or, that they constitute within themselves evidence of neurosis or even psychosis. If homosexual activity persists on as large a scale as it does, in the face of the very considerable public sentiment against it, and, in spite of the severity of the penalties that our Anglo-American culture has placed upon it through the centuries, there seems some reason for believing that such activity would appear in the histories of a much larger portion of the population if there were no social restraints. The very general occurrence of homosexuality in ancient Greece, and its wide occurrence today in some cultures in which such activity is not as taboo as it is in our own, suggests that the capacity of an individual to respond erotically to any sort of stimulus, whether it is provided by another person of the same or of the opposite sex, is basic in the species."

Psychoanalysts will readily recognize the fallacy of such reasoning, for it might be equally used to prove that neurosis is normal, inasmuch as it occurs in such a large proportion of the population. It is probably true that, were it not for social and cultural restrictions, there would be a greater number of overt homosexuals, but it is also probable that, even under circumstances where permissive attitudes existed, individuals practising homosexuality would still be responding to neurotic needs.

The work of Ford and Beach<sup>10</sup> would indicate the occurrence of homosexual activity in subhuman species, but their findings are not conclusive. It would appear that, although such activity does exist



in lower animals, it frequently is an indication of immaturity or is a result of frustration in heterosexual drives, although the authors themselves appear to consider it a normal activity in some stages of the development of the animal.

Deutsch<sup>11</sup> states, "The view that female homosexuality is in the overwhelming majority of cases psychologically determined, is supported by the fact that a great number of women whose sexual love objects are of the same sex do not give the impression that their physiologic characteristics have undergone changes in the direction of masculinity." Again, "Her homosexuality expressed not the existence of an organically determined urge, but an emotional need to love and at the same time to avoid her inferiority as a woman." Yet, in the very same manuscript, she says, "It is certain that normally puberty includes a phase in which the sexual drive is directed more or less toward both sexes."

At the risk of oversimplification, the following represents essentially the views of Freud and many of his followers on the subject: We are all basically bisexual. This is demonstrated by the remnants of both sexes in our biological make-up; and by the fact that we go through a period in life when we are normally predominantly homosexual in object choice. Normally, as we reach the genital phase of development, we repress our homosexual tendencies and assume a heterosexual existence. In all normal people, unconscious homosexual strivings can be discovered. In some people, whether for psychological, environmental or biological reasons, the individual is unable to repress these homosexual tendencies successfully; and, instead of remaining latent and repressed, they become overt, or precipitate a neurosis. Freud distinguishes between the individual who is able to repress his homosexual tendencies from the one who becomes overtly homosexual, the latter being difficult or nearly impossible to treat effectively with psychoanalysis. This distinction becomes somewhat difficult to comprehend, when it is further pointed out that one of the important areas of conflict of the psychoneurotic involves the attempt on the part of the individual to keep repressed homosexual drives from becoming overt. Freud, apparently, places the overt homosexual in a class by himself; and, either by actual statement or implication, assumes an organic basis for the condition. Yet, in another place, a letter from Freud<sup>12</sup> to the mother of a homosexual son, he states that homosexuality cannot be considered as an illness.



The Freudian concept of homosexuality implies, therefore, that it constitutes a basic conflict against which defenses have to be created; that, if defenses are inadequately created, it constitutes a neurosis, and, if defenses are not at all created, it is not a neurosis and, in fact, is not even an illness. This is paradoxical, to say the least. It also implies a biological capacity on the part of all of us to show erotic feelings, which are not neurotic in character, toward members of the same sex.

It is questionable whether the foregoing concept is consistent with present-day experiences in dealing with homosexual patients. The author is of the opinion that what is referred to as homosexuality, is only a symptom in a neurotic structure. He holds that, in fact, homosexuality cannot exist without neurosis, which is contrary to the original Freudian view that the neurosis is a defense against homosexuality. This may appear to be an unimportant quibble over terms; but it actually constitutes a basic difference in attitudes, for it sets up the proposition that the homosexual striving is not a primary conflict, but is secondary to neurotic needs. It makes a great difference in the ultimate handling of a patient whether the analysis reveals a basic conflict over homosexuality as the cause of neurosis, or, whether the apparent homosexuality is only an indication of underlying conflicts involving significant people in the patient's past life.

In the present patient, her attraction to women, that is, her homosexuality, is overdetermined. It is first, a means of regaining the love of the mother; second, a way of making the mother jealous; third, neurotic domination of the mother, or mother figure, which she was helpless to accomplish as a little girl; fourth, masochistic submission to the mother figure as a re-living of earlier experiences, as well as through feelings of guilt. Fifth, it is a defense against the mother's aggression on the assumption that one can neutralize an enemy best by being in close contact with him. Sixth, on an Oedipal level, this patient's homosexuality is the removal of the antagonist from the heterosexual love object. The writer asked a little girl why she insisted on having her mother sleep with her. She replied promptly, "I don't want her to sleep with my daddy." Other determinants are, undoubtedly, present. However, in no instance, does love, in the sense of tenderness, play an important role in this girl's relationship with other women. In fact, homosexuality is inconsistent with love.



Female transvestism, therefore, is not a manifestation of homosexuality but of a drive for masculinity. Qualitatively, it does not differ essentially from other similarly-motivated disturbances in the sphere of feminine psychology. The supposedly happily-married woman who is eternally competing with her husband is the more subtle prototype of the same problem. Homosexuality has no meaning except as a multi-determined manifestation of neurosis.

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## A METHOD OF EVALUATING PROGRESS IN PATIENTS SUFFERING FROM CHRONIC SCHIZOPHRENIA

BY D. H. MILLER, M. B.; J. CLANCY, M. B., AND E. CUMMING, M. A.

It is difficult to evaluate the results of therapy in chronic schizophrenic illness owing to the nature of the disease process and the possible variables which affect it. Close study of individual patients has often been made during psychotherapy, for example by Rosen,<sup>1</sup> but in mass evaluations of chronically ill schizophrenics the tendency has been to class patients as "improved" on the basis of their ability to make certain adjustments within the hospital sub-culture or in society outside. It is seldom stated whether a patient is making a social adjustment within the confines of his illness or whether there has been a modification of the psychotic process.

An attempt has been made in this paper to evaluate within a hospital\* the factors which may affect the illness by close observation of a randomized population in as controlled a manner as possible, in conditions which vary only within certain limits. Patients were observed by nursing staff and physicians and results were recorded, progress being evaluated from these reports. From the nature of the illness it was felt that the patient's own evaluation of his state was not meaningful, because of the difficulties of communication, and the fact that the patients studied had been ill for an average period of 10 years. The minimum duration of hospitalization was three years, the maximum 23. During this time, patients became conditioned to live as comfortably as possible within the confines of their psychotic illness, and they could give no "real" meaning to the words "well" and "unwell." From observation, it would appear that patients try to reach a state of equilibrium with their illness, a state which depends either upon relative inertia or stereotyped forms of activity. For example, take one patient who spent much of his time pacing the washroom. When another patient crossed his regular path he became disturbed, immediately moved from his usual path and, on inquiry, said that he felt "gashed."\*\*\*

\*Saskatchewan Hospital, Weyburn, Sask., Canada.

\*\*This example was produced by Jules Henry, Ph.D., associate professor of anthropology at Washington University, St. Louis.



It was felt that it was important to try to assess a patient's social performance within the hospital ward independently of the assessment of his psychotic state. The justification for this dichotomous approach is that in certain cultures schizophrenics appear to be tolerated or encouraged by the societies in which they live and—after the acute phase of illness is over—are able to function at a high level of performance socially.<sup>2,3</sup> It would seem from the description by anthropologists that these schizophrenics are suffering from what would appear to be a crippling psychosis in our culture. It appears likely that the inter-relationship of a schizophrenic with his environment depends to some extent upon the environment as well as upon the nature of his illness. If this is so, performance might change independently of any observed change in the psychotic state. To this end two parallel series of assessments were carried out, one by at least four nursing staff members independently of each other and of the authors, and one by two of the authors, (D. M. and J. C.) and two other physicians who were asked to define the patient's clinical status at intervals.

The latter two received no indication as to the location of the patient's environment or as to what treatment, if any, the patient was receiving. It would thus be possible to assess how much the foreknowledge of the patient's status by a physician affected his ability to make an impartial assessment. The authors, who were closely bound up with the patient's welfare and concerned with the progress of the investigation, might, it was felt, produce an evaluation which was not reliable. The method was also designed to study the effects of environment on social behavior and psychotic illness in chronic schizophrenics and to assess what difference environmental manipulation in the form of specific therapy might make. As observations were taking place continually, it was also felt that it might be possible to observe the way symptoms might fluctuate in a very chronic illness and also observe whether environmental manipulation affected this fluctuation. It would also be possible to judge whether, within the confines of his illness, there might be variations of a patient's social performance. All the patients studied had failed to respond to one of the following treatments or a combination during their stay in hospital: insulin, ECT, metrazol and hydrotherapy. None of the patients had received treatment for at least one year preceding this study. The average age of the patients was 35. All had been diagnosed on



first admission as schizophrenia, catatonic type; but, on studying their records, it was obvious that many, from time to time, had presented features suggestive of paranoid illness, hebephrenia and simple schizophrenia.

#### MATERIAL AND METHOD

Fifty male patients were selected at random from the Saskatchewan Hospital population of long-stay patients diagnosed on first admission as catatonic schizophrenia. Ten of these were further selected, and no change in their usual routine was effected, save a series of interviews with the assessing psychiatrists at intervals of two weeks.

The remaining 40 patients were moved to a new environment, designed to promote a high level of activity among the patients, and 10 more were randomized out as controls. The remaining 30 patients were thus available for special therapies under controlled conditions in randomized groups of 10. The specific therapies initially tested were ECT;<sup>4</sup> non-convulsive electric shock stimulation, with pentothal;<sup>5</sup> and pentothal alone.

These 40 patients were assessed on alternate days by the nursing staff on special forms for the purpose. The 10 controls, left behind in their old environment, could not be so observed, as it was felt that an uncontrolled variable would be introduced because they tended to be in wards with a standard of overcrowding which would make inconspicuous observation impossible. Once a nursing staff member had made his assessment it was handed to the ward supervisor and not made available to the evaluator again. Staff members were asked not to discuss their evaluations with each other.

The patients were grouped together in the ratio of one staff member to eight patients, on the basis of group assignment as devised by McKerracher.<sup>6</sup> The total period of observation recorded in this paper is eight weeks; and during that time, owing to the shift system at work in the hospital, each group was observed by at least four nursing staff members, two per day, who made individual assessments on the patients. Unless there was agreement between the staff members, their observations were discounted in the final assessment. This was possible because each patient was reported on 56 times. The assignment of staff members to patients was a random affair, and no attempt was made to place a



particularly good nurse in charge of a difficult patient. The staff members were asked to make a series of observations on the patients which covered the following points: the type of occupation carried on by the patient, his level of verbalization, whether he was neat and tidy, what help was needed for washing and shaving, and his toilet and eating habits. In addition the observers noted his ease of handling, particularly in relationship to whether they felt he was interested in his environment. Separate records were kept by the ward supervisor which recorded the incidence of any particular disturbance. No sedative drugs were given to the patients, and a record of breakages and clothing damage was kept.

These forms, filled in by the staff members were assessed by the two medical authors at four separate time intervals, each covering a five-day period. It was thus possible to give positive answers to the questions that are shown in Table 1. Any increase or decrease in the number of patients showing these qualities could then be assessed as to the statistical significance of the change. The method used to test differences was chi-square with the

Table 1. Categories Studied for Social Performance

No. of patients actively occupied. (Games, O. T.)	No. of patients passively occupied. (Cinema, shows, etc.)	No. of patients answering questions.	No. of patients clean and tidy.
No. of patients able to wash and shave without help.	No. of patients continent of urine.	No. of patients continent of feces	No. of patients who, staff felt, showed an interest in their environment.

Yates correction.<sup>7</sup> It is then possible to compare any treatment group to itself and to a control before and after receiving specific therapy. Comparisons for all criteria were made; and, whenever the difference was significant, this is recorded.

The environment was so designed as to afford ease of observation of the patients' activity and social behavior by the staff members concerned. It is discussed more fully by the authors elsewhere.<sup>8</sup>

Assessments of the patients' psychotic states were performed by three units of physicians at intervals of two weeks. Unit 1 consisted of two of the authors, Units 2 and 3 of physicians working independently. Unit 1 did not assess the control group left behind in



its old environment as it was felt that it was wise to disturb these patients as little as possible. These assessments were conducted in offices away from the treatment ward.

These physicians assessed the patient on the following factors: (1) his level of activity in the interviewing situation; (2) his appearance both as to general cleanliness and appropriateness of expression; (3) his responsiveness to the examiner's interviewing technique; (4) his mood—whether affect was preserved, whether it was present but unusual or inappropriate or where there was no obvious affect; (5) speech—whether diction was well outlined and spontaneous or in what way it was abnormal; (6) whether hallucinations were present; and (7) whether waxy flexibility could be elicited.

The last two qualities are dichotomous, but it is theoretically possible on a statistical basis to assess the first five into an intensity scale. It was decided to assess each of these qualities for the sake of simplicity on a grading of A, B, C, in which A can be considered to be the most nearly normal, C the most abnormal. The physicians doing the assessing did not in fact score the patients. All the assessments were collected together; and the remarks made as to each quality were independently analyzed and graded on the three-point scale. Although there is obviously some semantic difficulty, it was possible to arrange the remarks into three categories, A, B, C, as just noted, and then give each comment a rating score. Table 2 is an example of how this was done for responsiveness, but similar tables were made for all the qualities assessed except the last two, which were either positive or negative.

Table 2

(A)	
1. <i>Appropriate verbal response</i>	2. <i>Appropriate Environmental Response</i>
Obeys commands	Friendly
Constructive conversation	Leaves briskly
Spontaneous conversation	Effort to introduce himself
Uses decisive words	Holds out hand to be shaken
Gives an account of himself	In touch with surroundings
Initiates a conversation	Accepts proffered hand
Expresses preferences	Good attention
Speedy, appropriate response	Looks alert
Expresses an opinion	Good memory



## (B)

1. <i>Retarded Verbal Response</i>	(2) <i>Retardation of Action</i>	(3) <i>Inadequate Response to Environment</i>	(4) <i>Partial Disorientation</i>
Speaks when spoken to	Leaves slowly when asked	Orders examiner about	Disorientated in some spheres
Able to carry on conversation	Tries to make contact	Will hold hand—no grip	
Fairly responsive to questioning	Can carry out a simple command		
Answers questions with persuasion	Aware of surroundings but has difficulty in interpreting them		
Delayed response to questions	Obeys commands reluctantly		
Distant response	Willing to cooperate		
Vague response to questions			
Responds in another language			
Shy answers			
Answers simple questions, will not answer more complicated ones			
Shows interest in some subjects			

## (C)

1. <i>No Response—Verbal</i>	2. <i>No Response—Environmental</i>	3. <i>Inappropriate Response to Questions and Environment</i>
No verbal response	Limbs in same position	Inappropriate response to questions
Aware, but no response	Requires to be pushed through door	Same response to all questions
Doesn't answer questions	Does not obey commands	"I don't know," to all questions
Self-absorbed	Ignores surroundings	Incoherent and unintelligible
Understands questions, but does not reply	No reply to greeting	Mumbles with or without questioning
Ignores questions	Resists attempts to move him	Silly laughing response
Preoccupied with something else	Listens without replying	Smiles in reply to questions
	Inaccessible	Does not follow objects with his eyes
		"Snakes hands"
		Picks up objects
		Stuffs things in his mouth
		Disinterested
		Seclusive
		Resistive to attention
		Impulsive
		Blocking
		Restless
		Bizarre movements
		Answers on a delusional basis



4. <i>Disorientation</i>	5. <i>Stereopathy</i>	6. <i>Negativism—Automatic Obedience</i>	7. <i>Echoprazia</i>
Disoriented in all spheres	Stereopathy	Negativism Automatic obedience Attempts to write, but without result	Echoprazia

## RESULTS

The assessments made by the three units of physicians were analyzed for consistent agreement, and all 50 patients initially randomized were studied. With 50 patients being rated for seven items, there are 350 possible points of agreement. This agreement is as listed in Table 3.

In assessments 2 and 3, Unit 1 did not assess the controls, and the figures shown represent a correction for 50 patients.

Table 3. Agreement Between Doctors Over 350 Possible Points

	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Units 1 and 2 agree.....	203	213*	265*	203
Units 1 and 3 agree.....	201	200*	280*	217
Units 2 and 3 agree.....	230	213	215	222
All units agree.....	149	143*	211*	152

\*Unit 1 represents the authors. In assessments 2 and 3, they did not assess the controls, and the figures marked with the asterisk represent a correction for 50 patients.

The average agreement among all three units is more than 10 times as great as would be expected by chance alone. There is no significant trend toward greater or lesser agreement over the four assessments, although assessment 3 shows the highest concordance.

If the prior knowledge of the patients' treatment was to affect the assessment of Unit 1, it might be expected that there would be a trend away from agreement with the other units. It is obvious from the table that this did not happen, and it would appear that knowledge of the patients' treatment does not necessarily affect the clinical judgment of a patient that a doctor might make. It is clear that the presence of independent assessors must influence the degree of detachment of the doctors who carried out treatment, and this, therefore, need not mean that only one series of assessments should be made. The level of agreement shown by the various units is a maximum of 60 per cent, a minimum of 40 per cent. A psychiatric assessment is essentially subjective on the part of



the examining physician, and the lowest concordance was obtained on the assessment of a patient's appearance, which was on the whole constant throughout the examination day, although there might be some change as to the growth of a patient's beard and his appearance before and after meals. Since patients were presented to the examining physicians in a random order, this should

Table 4. Comparison of Agreement (Crude Figures) on Appearance and Mood of 50 Patients

	Assessment 1		Assessment 2		Assessment 3		Assessment 4	
	Appear- ance	Mood	Appear- ance	Mood	Appear- ance	Mood	Appear- ance	Mood
Units 1 and 2 agree .....	18	31	19*	34*	17*	36*	27	35
Units 1 and 3 agree .....	24	35	17*	34*	27*	39*	24	36
Units 2 and 3 agree .....	22	42	19	37	27	34	28	33
All units agree .....	11	28	8*	26*	15*	27*	16	27

\*Figures corrected for 50 patients

not have significantly affected the results. It will be seen from Table 4 that it was apparently much more difficult to obtain agreement on the appearance of a patient than on his mood; and yet it would have seemed likely that the latter was a much more subjective assessment.

In the scoring of patients, the lower score was used throughout whenever there was disagreement—on the assumption that the patient cannot, for example, be considered free of hallucinations if one of the assessing units distinguishes hallucinations. It is recognized that a patient who commonly hallucinates may, on any one day, appear free of hallucinations, and vice versa, but the chance of this happening is constant for all patients. In other words, the chance of a patient being observed, on assessment, to hallucinate, is a direct function of the frequency of his hallucinations and, therefore, over the whole group, other factors being constant, the relative proportion of hallucinating patients observed should be constant from assessment to assessment, unless there is a change in the psychotic state. Differences among the five groups of 10 patients were analyzed for each of the seven factors on each assessment.

It was found that the control groups shifted markedly from assessment to assessment, that is, both those for whom the environment was changed and those who were not moved from their usual



routine. This can be demonstrated if the two dichotomous factors of those hallucinating and those showing waxy flexibility are considered. In the control group whose members were not moved to the treatment ward the number found to be hallucinating varied from four to eight over the period of the assessments. This is a significant change. The number found to be hallucinating in the new environment varied from one to seven, which is again significant. Flexibility varied in the two groups from four to seven and four to six which is not significant. It is impossible to make a before-and-after comparison with this small group as it would appear that any differences in the psychosis might easily be part of the swing of disease. One cannot assume then that a new environment in which activity of the patient is stressed affects the patient's psychotic symptoms. If this swing in symptoms is considered to be operating independently of the experimental situation, it is possible to compare all the various groups on each assessment made. However, if the total of 30 patients who had received the various forms of treatment were compared to the total control group of 20, considering together those receiving no specific treatment, one suggestive difference emerges which is shown in Table 5 with a chi-square value corresponding to a probability of chance distribution of less than 5 per cent. The whole population tended to have progressively more hallucinations over the experimental period of two months, but the group receiving treatments of various types have, suggestively, more hallucinations by the fourth assessment. Since chi-square is on the borderline of significance, this observation may be worth repetition.

Table 5

	Assessment 1		Assessment 2		Assessment 3		Assessment 4	
	Treated	Control	Treated	Control	Treated	Control	Treated	Control
Hallucinating	20	10	26	14	27	18	30	17
Not hallucinating	10	10	4	6	3	2	0	3

Chi-square = 4.904911. Probability of chance distribution = .03.

It has already been stated that no estimate of social performance was made on the control group not moved; and, therefore, in studying the effects of environment, one must compare the control group on the active treatment ward to itself, on the basis of any difference between performance on arrival on the ward and performance at the end of the eight-week period. One can also see whether the



groups receiving treatment perform better than groups not receiving such treatment. Elsewhere the authors have compared the effects of each treatment and compared them to each other.<sup>9</sup>

Table 6 gives the performance figures for the group receiving treatment and the group acting as controls. It will be seen that there was an improvement in performance on all items studied for both groups; but, insofar as the control group was concerned, although the differences are suggestive, only the fact that all members became continent of feces is significant. As the patients were randomized, it is a chance finding that the treatment group mem-

Table 6

	No. actively occupied	No. passively occupied	No. answering questions	No. not helped to wash and shave	No. clean and tidy	No. clean, urine	No. clean, feces	No. showing interest in environment
<i>Treatment Group</i>								
On arrival on ward	12	20	13	11	15	21	27	1
After 8 weeks ....	28*	28*	18	18	19	22	30	13*
<i>Control Group</i>								
On arrival on ward	5	6	3	4	5	1	5	1
After 8 weeks ....	6	7	5	6	7	4	10	4

\* Figures are statistically significant.

bers were significantly more continent of feces initially than the control group. Insofar as the treatment group patients are concerned, they show significant improvement in their level of activity, both active and passive, and also in the number the staff felt showed an interest in their environment.

For those actively engaged in doing something, there is a net gain for the treatment group relative to the control group which is highly significant as chi-square=13.871409 and the probability of this being due to chance is very much less than 1 per cent. For those attending at entertainments of various types chi-square=4.658385; the probability of chance lies between the 5 and 1 per cent level. For those showing interest in environment, the treatment group is significantly more interested at the end than at the beginning, but there is no significant net gain over the control group, which in itself shows a gain which is not significant. Since all groups showed a steady increase in hallucinations, it would thus



seem that—while social performance is, in general, improving—the disease itself appears to become more acute. The relationship between the two is well shown if the performance of one of the patients is considered. It is felt that with this type of handling of the patients there may well be a breaking point, if a patient is pushed too hard; and, in this case, he will likely lose complete touch with his environment. An illustrative case follows:

The patient was a man of 44 who had been hospitalized with a diagnosis of catatonic schizophrenia since 1933. He was usually mute before admission to the special ward but was reported to have outbursts of catatonic excitement at about two-month intervals, when he became incontinent and unmanageable. When the patient arrived on the ward he was reported to be mute, untidy, seclusive, refusing all types of activity, dirty and incontinent of urine. Within seven days, he was reported as engaging in full activities, answering questions, talking to other patients, being neat and tidy and co-operative and helpful. The staff became very enthusiastic about his progress and tended to push him to even greater levels of activity. On the eighth day, he became acutely disturbed and restless, and this behavior lasted for a two-day period. At this point, the whole pattern was repeated, but, on this occasion, the improvement lasted 10 days. The patient then became disturbed for a two-day period again and then was well and active for five days. Again he became restless and aggressive until, on his next improvement, the staff was instructed to be a great deal more permissive and to allow him to go at his own pace. From that time on, his social performance remained at a high level; he was clean, active and verbalized to some extent. On clinical examination at the end of a four-month period, he still showed clinical signs of catatonia, but his disturbances appeared to have ceased.

Within the limits of this patient's illness, there is a range of social performance; and a relationship between environmental pressure and acute flare-ups of his psychosis is demonstrated. Since all the patients concerned began to hallucinate more obviously; it would appear that an improvement in environment, with more activity on the part of the patient, if not geared to the needs of the individual, may again lead to an acute breakdown and withdrawal from reality. If, however, the environment within the hospital is sufficiently well designed so as not to threaten the patients, they



are capable of an increase in performance without a change in the observed state of psychosis. This is borne out by the fact that the psychotic state of the control group on the active treatment ward did not change relative to the control group off the ward; and in the latter's case, there was no reason to assume that there had been any change in social performance.

### SUMMARY AND CONCLUSIONS

Anthropological investigations appear to justify a dichotomous approach in the study of chronic schizophrenics.

A method has been devised wherein it has been possible to assess the social performance and clinical status of a chronic schizophrenic in an active treatment ward. This assessment has then been submitted to an assay of statistical significance by the chi-square method.

Selection of patients was on the basis of randomization; and, thus, it was possible to discount many variables, as complete control of a patient or his environment is not possible. It is shown that knowledge of the patient's treatment and environment does not necessarily affect the ability of the physician to make an impartial clinical assessment as to a patient's progress. The subjectivity of this assessment is, however, demonstrated—in that it is most difficult to obtain agreement on a description of the patient's appearance. However, despite this, the concordance obtained was 10 times greater than chance would dictate.

The variation in symptomatology in chronic schizophrenia has been shown; but, despite this, certain trends were demonstrated by the method described in this paper.

If the following groups of patients are considered, a control group in an environment usual for it, a control group in an active treatment environment, and a treatment group in such an environment, the following factors emerge:

There is no difference between the clinical status of the two control groups.

The treatment group members, taken as a whole, show suggestively more hallucinations than the control group. The authors have discussed elsewhere,<sup>9</sup> the individual treatments given and have shown that they do not differ in their effects.

The number of patients showing better social performance increased for all groups on the active treatment ward. As regards



their activity level and the interest that the staff felt they showed in their environment, this increase was of statistical significance only for the treatment groups taken as a whole.

In a single case, the relationship between environmental pressure and acute disturbance during chronic breakdown is demonstrated. This can be avoided by suitable manipulation of the patient's surroundings. It would appear from the over-all results that this relationship might be general in all cases undergoing active treatment.

Within the limitation that acute breakdown may be precipitated by the hospital environment, the dichotomous approach to the study of a chronic schizophrenic reveals that a wide range of social performance is possible, and that this is to some extent independent of the observed clinical state of the patient. Performance increased most significantly in the treatment group members, and, in their case, the illness became more acutely evident, as shown by the observation that there was a suggestive increase in the number of patients exhibiting hallucinations.

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## OBESITY: AN ETIOLOGIC STUDY\*

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The gravity of extra poundage cannot be overemphasized. The obese may be popularly accepted as healthy or even envied as "fat and jolly," but can only be classified as most unfortunate, when the tremendous increase in incidence of cardiovascular disease, digestive disorders, joint pains, accidents and even suicides are considered. Obesity has been divided into the endogenous and exogenous types. In the former, the acquisition of fat is traced to a primary decrease in body metabolism due to an endocrine dysfunction. Although these cases are of great interest and are frequently reported in the literature, they form a very small portion of patients (3 per cent in Silver and Bauer's large group.)<sup>1</sup> In the exogenous type, emphasis is merely shifted from decreased expenditure to increased intake. Actually all obesity is alimentary; there is only one aperture by which such matter gets under the skin, the mouth.

The question of why people become obese, i. e., why some individuals ingest amounts of food in excess of their needs, was the subject of a joint investigation by the endocrine, anthropological, psychiatric, and social service departments of Jefferson Medical College, Philadelphia. To reduce the variables, the initial group was limited to obese white females, of whom 103 are here reported. Patients with hypothyroidism and others in whom obesity might be secondary were excluded. Some of these patients sought medical consultation primarily because of concern over their weight; others had various other complaints and were referred to the research group. Their inclusion in this group, however, indicates enough interest on their part so that they returned for the various studies. Unfortunately, but not unexpectedly, a number, upon learning the doctors did not have a magic cure, failed to make the repeated visits which would have been necessary for adequate psychiatric evaluation. However, even in these cases, the psychiatric

\*This paper reports the results of a study made at the Curtis Clinic and Daniel Baugh Institute of Anatomy of the Jefferson Medical College, Philadelphia. The patients were studied from medical and endocrine standpoints by Dr. Karl E. Paschkis, anthropologically by J. Lawrence Angel, psychiatrically by Drs. Robert R. Schopbach, Albert Kaplan, and Robert A. Matthews. Dr. Paul Swenson collaborated in radiologic studies, and Olive J. Morgan, Ph.D., carried out the psychologic tests. For advice and criticism, the writers are deeply indebted to Dr. Karl E. Paschkis.



material, plus information obtained by the other departments, especially those of social service and anthropology, permits some conjectures. The fact that only one patient availed herself of prolonged therapy (q. v.) indicates the common lack of any sincere desire to curb overeating.

### A. *Anthropologic Factors*

The hereditary factor in obesity has always been stressed. Rony<sup>2</sup> observed that regional lipophilia was a family trait often shared by parent and offspring and that identical twins had the same type of fat distribution although they might be of quite different weights. The steatopygea of Bushman women is a racial characteristic. The familial incidence of obesity in the present study is presented in Table 1. While it must be remembered that these families are selected by having at least one fat daughter, the occurrence of almost 40 per cent of obese offspring from average parents, over 50 per cent in mixed matings, and over 60 per cent

Table 1. Genetic Background in Obesity; Based on Descriptions by 98 Adult and 18 Adolescent Philadelphia Obese White Females

Type of mating			Offspring		Sons			Daughters (incl. subjects)			
Father	Mother	No.	Per cent	Total	No.	Obese	Per cent obese	No.	Obese	Per cent obese	Per cent obese
Fat × Fat		30	25.9	130	57	32	56.1	73	51	69.9	63.9
Fat × Avg.		18	15.5	70	32	13	40.6	38	27	71.0	57.1
Avg. × Fat		42	36.2	210	87	33	37.9	123	69	56.1	48.6
Avg. × Avg.		26	22.2	128	51	8	15.7	77	40	52.0	37.5

in fat × fat matings indicates some kind of segregation. Normally about 9 per cent of the offspring of average matings may be expected to become obese.<sup>3</sup> Even this percentage would probably be reduced after allowing for psychosomatic effects. Thus the likelihood of simple recessive genetic determinants is very poor. The data also do not fit any such simple hypothesis as two-gene dominant causation but indicate that a number of genes must be involved.

Anthropological studies strengthened this concept of a hereditary factor. On the whole, the present data indicated a retention of slightly juvenile proportions and morphologic traits, especially in the extreme endomorphs. Over a quarter of the group exhibited a particular excess of the "juvenile" fat pattern and a lack of



feminine body traits, with a tendency as much in the direction of the infantile as of the male. The menarche at 13.35 years indicates maturation slightly ahead of normal for the environment. The menarche at 13.0 years for those obese from childhood onward is even more suggestive of early maturation. Bruch<sup>4</sup> stresses that early-maturing children tend to be taller and bigger than their peers before puberty but also cease growing before those maturing at the usual age. Other things being equal these early-maturers should tend in adulthood to be shorter and stockier and to retain juvenile body proportions, since, as compared with the average, a greater proportion of their growth took place during childhood.

Furthermore, those who remain fat from childhood up, differ in body type from those who become fat only after pregnancy. Thirty-three subjects, fat from childhood, had an average somatotype of 6.0—2.9—1.4 which was slightly more endomorphic than the total group. Thirty-four becoming fat after pregnancy averaged 5.5—3.1—1.6 or slightly more mesomorphic than the total whose average was 5.83—2.88—1.50.<sup>5</sup>

A comparison of body builds between the 31 subjects who managed to lose 25 pounds or more at one time or another and those who did not do so revealed so slight a tendency of the former group toward mesomorphy as to be meaningless. The obese are not genetically uniform, but it appears that genetic factors do not directly determine the ability to lose weight.

### B. *Neurologic Factors*

The urge for food intake depends on stimuli from many portions of the nervous system. Physiologic hunger is produced by contractions of the empty stomach and other portions of the intestines, since hunger is felt even after bilateral vagotomy and complete gastrectomy. The paths via the vagi and vagal nuclei of the medulla to the thalamus are fairly clearly worked out. Experimental evidence,<sup>6</sup> however, indicates that the cortex, subcortex (especially the frontal lobes), and hypothalamus are most important in the production of appetite. Increased food intake and weight gain is of frequent occurrence after bilateral prefrontal leukotomy but is much less frequent after unilateral section.<sup>7</sup> This frontal area is an important cortical center for emotional stimuli. Long, et al.,<sup>8</sup> in their excellent work on hypothalamic obesity concluded that such lesions produced obesity as a consequence of increased appetite



rather than of any metabolic disturbance. When his animals were pair-fed, only one of 10 operated animals outgained its controls.

Wilder<sup>9</sup> thinks variations in the activity of diencephalic centers may well be hereditary in origin, and feels that the resulting changes in appetite explain familial obesity better than the cultivation of faulty eating habits. Bauer<sup>10</sup> argued the exaggerated viewpoint that, were obesity non-hereditary, all offspring of a fat  $\times$  fat mating should be obese. Actually it is true that should genetic factors play no part in the determination of the potentially obese, there would be fewer fat offspring of thin parents and many more fat offspring of obese parents. If hereditary factors are involved, they may sensitize the hypothalamus toward increased appetite in its response to fronto-thalamic emotional stimuli and visceral contractions, initiated by anxiety, hostility, or resentment. (The fact that similar psychic disturbances are reported to produce both ulcers and obesity becomes more comprehensible when the differences in hereditary anlage as exemplified by body build are considered. The person developing ulcers does not have the inherent potentialities for obesity.)

### *C. Psychologic Correlations*

Psychologically it becomes important to note what stresses precipitate excessive appetites in these sensitized individuals. Only 10 per cent of the patients studied were considered to fall within the limits of emotional normality. The remainder gave evidence of one or more long-standing disturbances varying from paranoid schizophrenia, hypochondriasis, and hysteria to prolonged enuresis, nail-biting, and distressing anxiety. This incidence and variety of clinical pictures has been reported elsewhere,<sup>11, 12</sup> but it is even more significant here since the writers' subjects were not primarily psychiatric patients. It is also possible that, had more complete study been possible, more psychopathology would have been recognized.

These subjects had suffered more than average stress as children. In about a quarter of the families, one or both of the parents had died during the childhood of the patients; and 16 per cent suffered deprivation through poverty. In 15 per cent, the parents were considered to have been excessively strict, but in almost an equal number the parents were overly solicitous. The family life of these individuals was further distorted by about a quarter of



the parents being separated or divorced and another quarter living together amidst constant friction. Only about one-quarter of the patients can be said to have had fairly normal healthy family lives. Marriage, as an escape from such unpleasant, unrewarding situations, frequently led to even more unsatisfactory relationships and may account for the high number of marriage failures. Out of 68 subjects only four described their relations with their husbands as good. Twenty-two described theirs as "average"; 18, as fair; and 24, as poor or very poor. Half complained of definitely unsatisfactory sexual adjustments and only a very few claimed real satisfaction. In over a third of the cases, pregnancy served as the precipitating factor for weight gains while in even a larger number a distinct aversion toward pregnancy was stressed (Table 2). It is also noted that marriage, often unsatisfactory, and menstrual changes (menarche and menopause) initiated the overeating of another 10 per cent, so that in about half of all cases, there was a very close relationship between psychosexual matters and the onset of obesity.

Table 2. Precipitating Factors

Factor	No. patients
Menarche .....	4
Marriage .....	6
Pregnancy .....	35
Loss of love object (parent or husband) .....	12
Operation or illness .....	8
Change of occupation .....	6
Miscellaneous (rejection, constant frustration, acute psychic trauma, etc.) .....	11
None discovered .....	21
Total .....	103

The fact that obesity is more frequent and more pronounced in females<sup>13</sup> and becomes more common in older age groups (except in the aged where the increased mortality has already claimed the obese) might be explained by the greater number of psychosexual problems encountered by the female than by the male and by the additive effects of life's stresses.

In studies by Bruch,<sup>14-17</sup> about 70 per cent of the obese children studied were the youngest or only children. Often the father was found to be weak and submissive and unable to give positive guidance to the child. At the same time the mothers displayed overt



solicitude and overprotectiveness in an attempt to conceal underlying rejection and resentment. In such an environment, which does not offer sufficient emotional satisfaction, food gains inordinate importance; it is offered and received not only for the appeasement of a bodily need but becomes highly charged with emotional values. This corresponds to the primary type of obesity of Rascovsky, et al.,<sup>18</sup> in which maternal solicitude excessively satisfies the infantile oral demands, destroying by anticipation the need for the organism to investigate the environment further. The ego becomes "fixed" at a preambivalent stage of orality, unable to handle daily frustrations of later life without undue tension and hostility. In the present writers' group the birth order showed no deviation from normal expectancy with six being only children and 21 being youngest. Absence of the father as an important figure and overemphasis of food as a symbol of love were, however, present in a number of cases.

Frequently the girl had remained of approximately normal weight until leaving her dependent role as a daughter to marry or, more especially, until after becoming a mother and having someone dependent upon her. Other incidents which forced responsibilities upon these women appear to create much tension and to cause regression to oral satisfaction. Although the responsibilities carried by a number of subjects appear from their accounts to be greater than usual, those subjects complaining most about their burdens had the lighter tasks. A third of these in whom this situation was studied regarded themselves as inadequate or overburdened.

Resentment toward husband, children, or other important persons was frequent. The fact that these women had not permitted themselves the expression of this hostility suggests a need of the patient to retain all sources of approbation and an excessive fear of incurring any disapproval. Recently Bychowski<sup>19</sup> indicated that compulsive eating, a cannibalistic introjective mechanism, may vent this aggressivity. Consumption of food is an aggressive masculine act, symbolic of earliest gratification by the mother, and places the subject in competition with the rest of the family for such solace. The initial purpose of retaining approbation and avoiding disapproval is thus defeated; instead anxiety and guilt result. These may further produce depression. In this series depression was prominent in only six cases. In these it was not



constant but recurrent in varying degrees. This is usually rationalized as guilt over not having followed the doctor's orders, but can usually be traced more deeply.

In a very few cases women who considered themselves unlovable or who felt undesired gained a fact in reality upon which to base their reasoning by eating and becoming unattractively fat. Their expressed dislike of any sexual activity suggests that it seemed easier to reduce sexual temptations through obesity than by more adult methods. Bychowski<sup>19</sup> also observed that once obese women lose their excess fat, one beholds creatures who fit the measurements of undeveloped girls.

After removing from consideration those who fell into the previous categories a large number remained for whom eating served a large variety of purposes. These might be expressed in either a neurotic or a psychotic setting. In general, however, overeating was associated with passivity, dependence, intolerance of responsibility, and repressed aggression, all amounting to emotional immaturity.

### CONCLUSIONS

A. Considering the anthropologic and psychiatric factors, we may postulate in obesity the presence of genes which (1) accelerate total body growth rate, (2) tend to stop both physical and emotional growth earlier than usual through effects on the adrenarche and menarche, and (3) sensitize the hypothalamic appetite mechanism. The presence of all three of these genes or groups of genes produces a *potentially* obese person. The occurrence of stressful situations may precipitate overeating which is usually accompanied by other neurotic or even psychotic solutions.

B. Frequent personality conflicts are with passivity, dependency, intolerance of responsibility, and inability to express aggression.

### CASE SUMMARY

A 37-year-old white woman returned for treatment by psychotherapy as an out-patient at the Curtis Clinic, Philadelphia, for over two years. Initially she was too heavy for the medical scales, but she tipped the freight scales at 317 pounds. She complained of extreme nervousness, excitability, and of "nervous headaches with a sick stomach" when upset. She described herself as over-



meticulous, fussy, disdainful of anything dirty, almost obsessively clean during her menses, and very concerned about financial matters.

Six months after her birth in North Carolina, she was taken to her maternal grandparents. An aunt lived with the grandparents, worked, and ruled the household in a domineering moralistic manner. The patient was the oldest of three siblings, and, when the two younger ones were brought from an orphanage this aunt chose the patient as her favorite, creating dissension among the children. The patient's brother died when she was 10, leaving a sister four years younger. The patient was unable to remember her siblings at all as children. Food was a source of solace even when she was young, especially as the aunt praised fatness as "cute." By menarche at the age of 14, she weighed 219 pounds.

The aunt was always preaching some moral or protecting the patient by locking her inside their fenced yard. This and the aunt's constant presence drove both other girls and boyfriends away. The aunt would give her approval to the patient's actions, only if tasks were completed with the utmost scrupulousness. The patient considered her a paragon of virtue and obeyed her implicitly. More recently the patient discovered that this aunt had been doing just what she had been hypocritically preaching against to the patient. Despite intellectual recognition of this and resentment of the aunt's continued domineering ways, the patient, before therapy, was unable to accept the reality of having any hostility toward her but was continually disturbed in her relations with the aunt.

The patient saw little of her mother until she herself was 19, as the aunt disapproved of the mother's marriage and refused to allow her to visit her. Occasionally the mother would sneak in while the aunt was at work. The patient has never seen her father whom the family has always described to her as a black sheep. When the patient was 19, the mother reclaimed the children and went to Philadelphia where the patient obtained work. The mother and sister made occasional ineffectual efforts to obtain employment but usually ran up such heavy bills for unnecessary trivia that they could not pay the rent and would be evicted. The patient felt so insecure that she took an evening business course, and a nursing course, and also learned to operate many types of sewing machines so that come what may she would be prepared. Upon learning that her sister was pregnant, she expelled her from the household.



Shortly thereafter the patient fled the situation by way of marriage. Although she gained much-desired financial security, her husband openly philandered. During a period of indecision, she put on a great deal of weight. However, after separating and finding work with a couple who took a sincere interest in her, she lost weight. "I lost 60 to 70 pounds. I was content." When her husband was hospitalized as psychotic and then died of a brain tumor, she felt very guilty and somewhat confused. In order to retain her home and to gain some advice, she married a friend of her husband's. Prior to therapy she was only aware of a vague admiration, not love, for this man, and even this was tempered by the fact that his seasonal work as a carpenter had not yielded the security she had sought. Likewise she resented his passive attitude. "I wish he would take some initiative, but he leaves everything up to me. I married for security but he leans on me."

This substitution of eating for security and affection was one of the first points utilized in therapy. She gradually came to see that she was making excessive, romantically idealistic, demands upon her husband and others, while not encouraging them by making initial friendly overtures. She had been hurt before and did not wish even to take a chance on being hurt again. Gradually this attitude and the behavior associated with it changed until, for the first time, she cut a trip short because of a loving longing for her husband. Friends remarked on her change of attitude from, "People say I am always wrong; no one likes me," to, "Maybe they won't like me and may hurt me, but I'll give them a chance."

Only with much trepidation did she transgress her early teaching of keeping all feelings bottled up. Her recognition, even in graduated small doses, of her strong hatreds and resentments was very disturbing. The evening before, and morning of, her appointments she frequently developed nausea or headaches which were promptly interpreted and accepted as resistance phenomena. "Whenever I don't want to do anything I get sick at my stomach." Occasionally she would give in to them but usually came despite their occurrence to experience a subsidence once the session had begun. Gradually she was able to verbalize her negative feelings more readily in the sessions, and was able to discuss them with her aunt and husband so that improved relations with each of them resulted.



In 10 months she had made fair psychiatric progress but had only lost 11 pounds. At this point she was given amphetamine (S K. F-42) before meals, as it was imperative for her to lose weight before undergoing an operation. She immediately complained of nausea and vomiting, dizziness, a sensation of being in a trance, retardation of movements, and a feeling that her voice belonged to someone else. The drug was continued. After about two months she spontaneously stated that the symptoms had been a resistance against losing weight. "Every time I've heard I've lost weight, I've fought against it. I'm afraid to lose it. I want to lose weight but, when I'm conscious of losing, I get sick at my stomach and all upset. Maybe people would be sorry for me if I'm fat. No, people leave me out of things because I am fat." (She gains sympathy and reduces interpersonal contacts, v. s.) Following this she had no more such symptoms and, during the ensuing year, reduced her weight to 250 pounds.

Unfortunately it was necessary for the therapist (R. S.) to leave the clinic area and for the patient to continue with another. She became irritable, fatigued, slept up to 11 hours a day, had headaches, and gained eight pounds in three weeks. She recognized a great resistance against coming for therapy, verbalized feelings of rejection by her former therapist and of uncertainty about her new therapist. "I don't know you. I'm always afraid of expressing myself for fear of being hurt." About this same time she obtained a daytime job, as her husband was again out of work, and she discontinued therapy.

Psychological tests indicated an IQ of 126 on the Bellevue-Wechsler Scale. The Rorschach and Szondi tests showed great constriction through the extreme anxiety of repressing her instinctual drives. There appeared to be a basic need for emotional detachment. However, in her intimate relations, she appeared cold and cautious until strongly stimulated when she lost emotional control in immature impulsivity. In her less intimate relations, she appeared to adapt better, but only through compulsive repressive means among which eating was prominent. By allaying anxiety in that way she could be relatively indifferent in her object relations, making few demands upon them.

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## SIMULATION OF PSYCHOSIS

### *A Report of Three Cases\**

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While on the psychiatric service of an army general hospital in the Far East, the authors of this paper recently observed three cases of attempted malingering which they believed to be of especial interest for several reasons. In the first place, all three patients attempted to malingering a psychosis, which in the writers' experience had been a rare occurrence among the large number of psychiatric patients observed at this hospital. Second, they each had basic personality disorders of which the malingering was only one aspect; and there was no common denominator in the basic personality defects which one could readily correlate with the malingering. Third, in all three cases historical and clinical suspicions of malingering were confirmed by significant findings on psychologic test results. And finally, very little work has been published on the subject of malingering, particularly malingering of a psychosis.

Malingering is defined by the army as "The intentional, calculated attempt to produce or simulate illness or injury for the purpose of evading duty or responsibility." This was used as one criterion for establishing the diagnosis of malingering in the cases here presented. An additional criterion adopted by the authors was absence of true psychosis. All three cases fulfilled the first criterion of a conscious and premeditated attempt to evade duty by feigning an illness. Two of the three also fulfilled the second requirement of having no mental illness. They were, therefore, recommended for appropriate administrative disposition. The third patient, Case 1, as will be seen, was also suffering from a true and severe mental illness which required psychiatric treatment. The malingering in his case was regarded as merely a symptom of his illness and was of academic interest only. It had no bearing on the final disposition of the case.

Since at this army hospital (141st General Hospital), routine psychologic testing is not done on all psychiatric patients, tests are ordered by the psychiatrist only in cases of unusual interest or in

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those cases in which tests would prove helpful in diagnosis and treatment. In all of the cases presented here psychologic tests were ordered specifically because it was believed from the history and/or the clinical picture that there was a strong possibility of malingering. As all three of the patients were believed to be feigning psychosis, the psychologist was asked the following two questions: (1) Is there any evidence of distorted thinking that would indicate a psychosis? (2) Is there any evidence of a conscious attempt to malingering a mental illness?

### THE CASE MATERIAL

#### *Case 1*

This 28-year-old, white air force staff sergeant with four years of air force service was transferred from a nearby air base dispensary with a diagnosis of "manic-depressive reaction." The patient had served in the air force for three years during World War II, and apparently had had a good military record, terminated by honorable discharge. He re-enlisted about one year prior to this hospital admission and had been stationed in Japan for two months. He worked as a clerk and discharged his duties efficiently. During the two weeks prior to admission, his commanding officer noticed that the patient was drinking more than usual and that his efficiency at work had decreased noticeably. On the day of admission he drove off in a jeep without authorization, and, when apprehended, behaved so oddly that he was taken to the dispensary. There he was observed to be hyperactive and confused, so that he was immediately transferred to the hospital for psychiatric observation.

*History.* The history, as obtained from the patient, was not very helpful because of his mental condition, and there was no available outside source of information. He did disclose, however, that he had done fairly well in school and had completed two years of college. During the five years between his two tours of military duty, he had lived in southern California and was employed as a draftsman in an aircraft factory. He was interested in the theater and occasionally acted in little theater groups. There was no history of any previous psychiatric disorder.

*Mental Examination.* The mental examination on admission revealed increased psychomotor activity and overproductive speech.



This speech was circumstantial, and at times irrelevant. It was marked by clang associations, perseveration and a concrete fascination with words. The patient was very manneristic, exhibiting frequent symbolic gestures, such as exaggerated saluting in the presence of an officer and complicated motions of the hands that elaborated on what he was saying. He said that he heard voices saying that he looked like a certain well-known Hollywood actor (there was a superficial resemblance). No paranoid delusions or ideas of reference were elicited. He was well oriented in all spheres.

The clinical picture appeared typical of a schizophrenic reaction, and this was the initial diagnosis. Subsequent information obtained from the patient's commanding officer, however, revealed that the patient had recently inherited a fairly large sum of money—about \$2,500. He then remarked to several of his friends that he would get home "any way I can." When he was questioned concerning this information, he at first denied it and then became very evasive. His mental status became less dramatic, but mannerisms and inability to form normal, abstract, intellectual concepts continued. Psychologic tests confirmed the clinical impression that this was a case of a schizophrenic attempting to malingering a psychosis. This impression was based upon the early overdramatic qualities, the history furnished by the patient's commanding officer, and the patient's evasiveness and change in mental status when confronted with that history.

A poignant development in this case was the gradual realization by the patient that the medical officers knew of his deception and that they, nevertheless, considered him mentally ill. He declared that he had been "playing a dual role" and that now "the play has become a sort of tragic comedy." It was difficult to determine how much was conscious acting on the part of the patient. It was believed, however, that the prognosis was grave, and that he could not be rehabilitated for military duty. He was, therefore, evacuated to the Zone of the Interior for further treatment and final disposition.

*Psychologic Evaluation.* On all tests there was evidence of marked qualitative variations, deviant verbalizations, queer content, and bizarre percepts. This patient gave a schizophrenic record on the Rorschach, the Wechsler-Bellevue Intelligence Scale and the Thematic Apperception Test. Despite the pathology clearly implied, the Rorschach was less dramatically deviant than the TAT



and the Wechsler. The patient's approach was orderly, his form level was good, and his content generally acceptable. It is true that when he did give deviant responses on this record, they were of a very serious nature such as contamination, M minus, and over-symbolization. It was on the TAT and Wechsler, however, that he became dramatically bizarre, grossly illogical, markedly disjointed and acted more like a popular conception of the psychotic. As with his clinical symptoms, so were his responses on these two tests, overdramatic. It is believed that the Rorschach (which offered him no frame of reference) elicited a truer picture, while the TAT and Wechsler represented an attempt by the patient to give the impression of a more serious illness.

*Diagnosis.* Schizophrenic reaction, type unclassified, chronic, severe, manifested by mannerisms, concrete thinking, and episodes of manic behavior.

### Case 2

This 18-year-old, white, single private first class, with one year of army service, was transferred to the 141st General Hospital from an evacuation hospital in Korea with a diagnosis of "psychotic reaction, n. e. c." He had been in combat in Korea as an infantryman for about five months when he was evacuated because he appeared confused and disturbed. He repeated over and over again that he had accidentally shot and killed his buddy three months prior to admission. He said that since that time he had become more and more depressed and could no longer continue in combat. It was reported by his unit commander that he had been an ineffective soldier and would not fire his rifle at the enemy. Notes accompanying him from the evacuation hospital described him as agitated, confused and at times disoriented.

*History.* The patient said that his parents had been divorced 13 years ago and that he and his older sister lived with his mother. He said that his mother was both physically and mentally ill, but he could give no further details about her condition. He had quit school in the tenth grade at the age of 16 to go to work to help support his mother. His work record was relatively poor until he enlisted in the army a year later. According to the history from the patient, his previous army record had been good.

*Mental Examination.* The mental examination revealed a rather agitated young man who was very dramatic both in telling his his-



tory and in his actions. He had a slight tremor and shook his head to and fro constantly, stating that this eased his severe, throbbing headache. He appeared superficially to be confused, but was well oriented in all spheres, and his answers to questions were relevant. There were no apparent delusions or hallucinations. He kept repeating over and over, "I won't go back to kill anybody. . . . I'm going to Hell. . . . They are all going to Hell. . . . They are killing people." Frequently, during the interview, he would appear distracted and stare off into space.

The initial clinical impression was that this was not a psychotic reaction, but merely the manifestations of a hysterical character. It was then observed that the man's behavior on the ward varied considerably when he noticed the presence of the ward doctor, from his behavior when he thought he was not being observed. When he realized that he was under observation by the doctor, his behavior was as just described in the mental examination. Otherwise he appeared rather calm and showed no evidence of confusion, agitation or head-shaking. This aroused a suspicion of malingering, which was confirmed on psychologic testing. The patient was informed of the suspicions of the staff, and also of the fact that he was not considered to be mentally ill. He was returned to duty with a stern admonition that further similar behavior would result in disciplinary action. A recommendation was sent to his unit for administrative disposition if he continued to be an ineffective soldier.

*Psychologic Evaluation.* The patient's production on the Wechsler-Bellevue was markedly unlike that elicited on the Rorschach. On the Wechsler-Bellevue, his answers were recklessly wild. Example: "London is in France," "The capital of Italy is Prague." His judgment was impaired. Example: If he found a stamped, sealed and addressed envelope, he would "find the owner." His performance IQ (70) was much higher than the verbal IQ (55). On the Rorschach, a different pattern emerged. Evasion was expressed by increased initial and average reaction times, minimal responses (12), rejection (1), asking the examiner to tell him what people are supposed to see in "these things anyway." Percepts had good form but were of the variety classified as "cheap." There were many easy D and P responses. No wholes were of a truly integrative variety. The dramatic failure on the WB, the extreme change of pace on the Rorschach, the evasiveness and even "cagi-



ness" of the patient in dealing with unstructured stimuli, all suggested that this patient achieved a full scale IQ of 57 by deliberately trying to depress his score on the WB where he knew what constituted an incorrect answer. On the Rorschach, where he had no frame of reference he resorted to evasion and blocking.

*Diagnosis.* Emotional instability reaction, chronic, severe, manifested by low tolerance to stress, episodes of disturbed behavior and possible desire to evade duty.

*Postscript.* After leaving the hospital, this patient continued to make concerted efforts to evade duty. He sought aid from at least two chaplains and from the Inspector General's Office. He even managed, a few days after leaving the hospital, to get admitted to another medical installation because of the behavior described in the foregoing. However, he was immediately transferred to the same hospital and quickly returned to duty for the second time.

### Case 3

This 22-year-old, single, Negro private first class, with three and one-half years of army service, was referred to the neuropsychiatric clinic for psychiatric evaluation. He was awaiting court-martial for a 10-week period of absence without leave, and there was some question as to his present mental status and his mental status at the time of the offense. He had gone AWOL seven months before this examination, and, after being apprehended 10 weeks later, was confined to the stockade. While in confinement he made two suicidal gestures, one by hanging himself and the other by jumping from a wall. He was admitted to a station hospital for psychiatric observation and subsequently transferred to the neuropsychiatric service of the 141st General Hospital. The medical officer who observed him at that time noted that the patient refused to talk when first admitted, and later complained of vague feelings of strangeness and of seeing "visions" of strange people. He claimed complete amnesia for the period of absence without leave and confinement in the stockade. The diagnosis at that time was schizophrenic reaction, catatonic type, and evacuation to the Zone of the Interior for further treatment was recommended. However, because of his prisoner status, he was transferred to another hospital in the Far East for disposition.



Soon after arriving at the other hospital, he managed to escape, and was AWOL for about five weeks. He was apprehended by military police and suffered a minor injury to his foot while attempting to break arrest. When returned to the general hospital from which he had escaped, he again refused to talk for the first few days of hospitalization. There was evidence that he had been drinking heavily during the five previous weeks. He was discharged to full duty three weeks later, with a diagnosis of "alcoholism" and a certificate recommending administrative disposition. While in the hospital, he had exhibited no evidence of abnormal behavior or psychotic thinking. During the subsequent month, until he was referred to the clinic for examination, he carried on his duties in a normal manner.

*History.* The patient had had two courts-martial in the past—a summary court-martial two years previously for one month of absence without leave, giving a false official statement, and using an altered and forged certificate; and a summary court-martial one year previously for wrongful appropriation of a government vehicle. He was in combat in Korea for four months and was evacuated because of "nervousness." He was hospitalized for 20 days and then assigned to duty in Japan. Prior to the absence without leave for which he was to be court-martialed, he had twice before walked off his job and claimed amnesia for these episodes. His general attitude was recorded as one of belligerence and un-cooperativeness. The patient stated that his father died shortly after his birth, and that he had quit school in the tenth grade to help support his mother. He said that he had been a professional boxer prior to entering the army. There were many points in the history given by the patient which were at variance with the facts officially recorded.

*Mental Examination.* The mental examination revealed a rather stolid individual with no apparent anxiety or depression. He claimed complete amnesia for certain periods, as described in the foregoing history. He also stated that he still had vague feelings of strangeness and occasionally heard voices calling his name. However, he appeared clinically to be in good contact with reality, and it was suspected that he might be attempting to malingering a mental illness. Psychologic tests were administered and confirmed the clinical impression of an anti-social personality feigning a severe mental illness. He was returned to his unit with a



recommendation for administrative disposition after whatever disciplinary action was considered indicated.

*Psychologic Evaluation.* The test battery results were characterized by striking qualitative differences on the individual tests. While he achieved a full scale IQ of a mental defective on the Wechsler-Bellevue (IQ 57), the estimated Rorschach IQ was well within the normal range. Reaction time in each test differed considerably, Rorschach percepts coming forth with apparently greater reluctance and hesitation than those on the Wechsler. In responding to the Rorschach, the patient continually appealed to the examiner for a hint as to what was expected of him. Although formal qualities were deviant and defective on the intelligence test, they were quite acceptable on the Rorschach. Percepts were clearly seen and well integrated. Content was not spectacular. Determinants were not remarkable.

His pattern on the Wechsler was consistent. He would answer the first few questions satisfactorily and then begin to give defective responses. Consequently, there was practically no scatter among the subtests. When pressed on a particular item, he would eventually give an acceptable answer, thus indicating that he was capable of doing so from the start. It was, therefore, felt that the patient had made a conscious attempt to depress his Wechsler score and to give distorted and atypical responses.

*Diagnosis.* Anti-social personality, chronic, severe, manifested by repeated absences without leave, poor social adjustment, two suicide gestures and an attempt to malingering a mental illness.

#### DISCUSSION

These three cases illustrate pointedly the need to consider malingering in the light of the underlying personality pattern, and not as an isolated entity. No two of the foregoing cases were alike. The first patient was a true psychotic, who, incidentally, was malingering a psychosis. The second was an immature, emotionally unstable individual, who was "acting out" in a hysterical manner. The third was a coldly calculating anti-social personality, who would probably fall into Cleckley's<sup>2</sup> group of true psychopaths. In all three cases, however, the attempt to malingering was on a conscious level, and all three chose to malingering a psychosis.

There was a marked dissimilarity in the types of situation from which each malingerer was trying to escape. In the case of the air



force sergeant, it was a relatively mild stress of overseas duty in Japan. In the case of the infantry soldier, it was the very marked stress of combat. The third case, so often seen in civilian as well as military life, was an instance of a person attempting to escape from the consequences of criminal behavior by feigning illness.

One can only speculate as to why these particular individuals chose psychosis as the type of illness to mangle. In the case of the schizophrenic, it might be said that it would be only natural for a schizophrenic attempting to mangle a mental illness to choose schizophrenic symptomatology. Bowman,<sup>3</sup> in 1920, pointed out the relatively high incidence of psychotics malingering psychosis. This may represent a kind of schizophrenic withdrawal from reality.

With the presence in the same individual of both unconscious—or real—schizophrenic symptoms and conscious—or mangled—schizophrenic symptoms, it is interesting to speculate which of the two came first, which is cause and which is effect. It may be that a schizophrenic break had been impending in this case for a long time, and that the malingering episode represented a dropping of defenses against the psychosis. If this were so this dropping of defense could be on either a conscious or unconscious level, or on both. In any event, the writers believe that such a surrender would portend a very grave prognosis. Another possibility is that this patient's actions may have been a symbolic cry for help from a very sick patient.

Although it is usually difficult to make an absolute statement that a man is malingering, it would appear from the writers' experience that psychosis is an extremely difficult illness to mangle without arousing strong suspicion. In only one of the three cases described did the patient get by the initial interview without alerting the examiner to the possibility of malingering. This was the case of the man who actually was suffering from a schizophrenic reaction. Although it was noted when he was admitted that his symptoms were somewhat dramatic, even for a schizophrenic, there was no thought that he was malingering until this possibility was called to the writers' attention by subsequent history received from outside sources.

In each of the other cases, suspicions were aroused by several features of the clinical picture. The young infantryman appeared



to be excessively dramatic; and, although he had a superficial air of confusion, there was no real evidence of disorientation, defective thinking, delusions or hallucinations. The marked change in his behavior when he knew he was being observed was especially striking. The third man gave a history of vague feelings of strangeness and hallucinatory experiences, but showed none of the real emotional reaction that one would expect from a schizophrenic relating such a story. He also failed to show any loss of conceptual thinking although this was difficult to judge because of his evasiveness. His facile explaining away of his alleged criminal acts by claiming circumscribed periods of amnesia was also highly suspicious, as were the numerous points where his story varied from established facts.

In the psychological tests, suspicions were first aroused by inconsistencies between the individual tests within the battery. In general, these were expressed as dramatic and deviant performances on the TAT and Wechsler, while the Rorschach yielded evasive but less distorted records. In general, the Rorschach was viewed by the patients as threatening, and was met with reluctance and with appeals to the examiner for clues on how to respond. This was not the case in those tests where the patient had some idea of what a deviant answer would be. The Wechsler was usually characterized by grossly irrational responses which depressed the raw scores on all the subtests. Scatter analysis among the subtests revealed a caricature of what appeared to be the basic personality organization of each patient. Thus, the schizophrenic subject, the one with character disorder and the hysteric exaggerated in the direction of each of their respective disorders. The TAT in the case of the schizophrenic was similarly felt to be an exaggeration by the patient of bona fide symptomatology.

### CONCLUSIONS

1. Malingering cannot be considered as a separate clinical entity, but only as one manifestation of an underlying personality disorder.
2. There is no specific personality disorder common to all cases of malingering.
3. The attempt to malingering a psychosis can be detected without undue difficulty if the examiner is alert to certain incongruities in the clinical picture.



4. Psychologic tests, when considered in the light of clinical findings, are very valuable adjuncts in establishing a diagnosis of malingering where there is simulation of a psychosis.

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# SAMPLES AND CONTROLS IN PSYCHIATRIC RESEARCH

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## INTRODUCTION

The establishment of the Rockland Research Facility late in 1952 provides a unique opportunity for investigation of deviant behavior. The staff was drawn together (from all parts of the world) by the shared conviction that a common conceptual framework must be evolved that is capable of including within itself all the sciences and disciplines concerned with the description and investigation of deviant behavior. Since most of the researchers were already trained in two or more fields, it was possible to begin working into this new area with unusual ease; the "sets" and prejudices of the single field specialist being at a minimum. The following paper is one of a series which critically reviews the methods, theories, and presuppositions of the social and biological sciences as they apply to our problem.

## CRITIQUE

The purpose of scientific research in psychiatry, as in the physical sciences, is to control, predict and explain. One can begin with explanatory theory and seek for deduced empirical correlates or follow the reverse course of building a theory by induction to "fit the facts." In either case scientific procedure requires classification; the separation of the material being studied into identifiable classes. The attributes (properties) of such classes of individuals or objects provide one essential source of observational data. The other great source of "raw data" is the effect on such classes of identifiable procedures including "naturally occurring" environmental determinants as well as more specific experimental procedures. Ultimately, on the basis of results obtained by the application of these two basic techniques, the generalizations which constitute the "laws," mechanisms or principles of science are deduced and induced. Attributes of classes constitute such properties as the hardness of gold, the speed of light, the iodine uptake of schizophrenics, and the degree of anxiety in neurotics. Heat-

\*Considerable clarification of many of the major points of this paper resulted from conferences with Dr. Donald L. Gerard. However, the author assumes full responsibility for the final formulation.



ing the gold, "bending" the light, giving thyroid-stimulating hormone and administering psychotherapy are all examples of procedures which may then be evaluated in respect to how they affect the gold, the light, the schizophrenics and the neurotics.

The apparent ease of such experimentation in the physical sciences is the result of standardization of techniques suitable for inorganic matter and may be highly deceptive if these same methods are applied directly to the biological sphere. This has been particularly true in investigations of deviant behavior, and one of the least recognized but most important sources of experimental error has been the selection of samples and controls with the uncritical assumption that the manner of selection used in the physical sciences is perfectly adequate for biological material.

There exist, however, important and crucial differences in the nature of psychiatric samples and controls which must be recognized and acted upon if results are to have validity or even reliability. In the physical sciences, one ingot of standard 24-karat gold, for example, is as good as another if conditions are identical; or one beam of white light under standard conditions can be expected to behave just as any other would. The assumption has been blithely made that one group of schizophrenics (or any other diagnostic group) is as adequate as another in determining attributes or the effects of procedures. Whether atoms of gold possess "individual differences" is, for most purposes, a purely academic point, since they are ordinarily dealt with in such large numbers that any individual peculiarities are cancelled out; and the conclusions, although perhaps statistical in their final analysis (as Reichenbach<sup>1</sup> maintains), are reliable and valid for all practical purposes. This permits dealing with the object matter of the physical sciences as a field of what Weaver<sup>2</sup> describes as "unorganized complexity."\* The limits of populations to be investigated in psychiatry are determined not only by economic feasibility and available manpower, but by the very fact that certain classes of deviant behavior, even if taken in their entirety, would be infinitesimal compared to the number of atoms in a sample of gold. Consequently, one cannot take a sample consisting of 1,000 schizophrenics and assume the "individual differences" will cancel out so that the sample can be assumed to be equivalent to another sam-

\*Where the "complex" of material is of such a nature or size that any organization into subclasses can be ignored, i. e., considered as "unorganized."



ple of 1,000 schizophrenics, or comparable to 1,000 manic-depressives or psychopaths. Without the consideration of other qualifications, there is no assurance that the attributes of this particular group or the effects of certain processes on the particular group would have reliability or validity for individual cases or even for other samples of the same size.

Physical nature is also considerably more kind in usually holding still while it gets investigated. Even when physical elements are changing, they generally do so in a regular or predictable manner (e. g., radium). Biological material, particularly psychiatric, squirms about and transfigures itself in an un-co-operative manner. Until the "laws" governing such behavior are much better known, we must use methods which take cognizance of this extreme motility. The striking reactivity of biological organisms to test situations and instruments multiplies Heisenberg's principle of indeterminacy to the  $n$ th degree. The application of a sphygmomanometer probably changes the blood pressure; questioning a patient about his hallucinations undoubtedly effects the nature of the voices or visions. Some excellent methods have been devised for dealing with this problem; but in many fields of psychiatric investigation there still exists considerable naïveté in assuming that the effect of the test situation itself can be neglected.

In the physical sciences, it is also generally possible to isolate "pure" samples of whatever it is one wishes to study. In the field of psychiatry one cannot obtain an uncontaminated sample of the id, of schizophrenia, or, for that matter, of adrenal 17-ketosteroids. Occasionally, this obtaining of a "pure sample" is relatively possible, as in a recent study where 2,970 subjects were rejected on the basis of as few as 12 "complicating" factors to obtain 30 "pure" cases. But general conclusions drawn as to the child-rearing tactics and attitudes of the parents of schizophrenic patients on the basis of this study are highly questionable since they were not studied in the context in which they are usually found.

The interrelatedness and lack of functional independence in the biological sciences exceeds anything in the physical sciences. Pressure, temperature and the few other physical "invariable variables" can be either controlled or measured. The biological organism at the human level has interdependent respiratory, circulatory, urogenital, gastro-intestinal, and nervous systems, none of which can be held absolutely constant or tested separately. Thus, not



only is it impossible to obtain pure samples but it is also difficult to control or measure the factors influencing the "in context" sample.

Another contrast between the physical and biological sciences is the interesting fact that organisms probably behave as something other than the sum of their individual parts, even if these could be completely investigated. The uniqueness of an individual is something over and above the sum of its parts. It is impossible to subdivide samples of a particular individual—as can be done with inanimate objects—and assume that each part is representative of the whole.

The final and most essential difference that bedevils the investigator, at the level of research, is the validity and reliability of taxonomy. The classes, types and groupings of individuals having mental disease possess little of the concreteness and testability of classifications in the physical sciences. Class criteria have not been firmly established, and failure to find them probably indicates the inadequacy and inaccuracy of present diagnostic categories. The writer's personal feeling is that this has resulted from a failure to approach this problem experimentally.<sup>3</sup> Regardless of the reasons or the solution, we are all well aware that a group of "schizophrenics" does not possess the operational definability or the theoretical integrity of the gold ingot.

Most of the biological sciences, and psychiatry which is our particular concern, have certainly not advanced to the stage where the methods of sample selection and control analysis can be adopted *in toto* from the physical sciences. Even more fundamentally, it is probable that an adequate description of the material with which we work will never be obtained with a model constructed to deal with inanimate nature. It is necessary to use methods of sample and control selection more compatible with our present stage of development and with the nature of the material with which we are dealing.

#### REPRESENTATIVENESS

In the search to provide valid generalizations about attributes or procedures, it is impossible to study the total population. The obvious requirement is that the sample selected should be *representative* of the larger aggregate from which it is drawn. When groups are contrasted to determine attributes or divided to test



the effect of processes, the groups contrasted should be truly *comparable*. The following pages deal with these problems of representativeness and comparability as they apply to the area of deviant behavior.

The most common error made in the choice of samples for psychiatric research is to select samples solely on the basis of the currently accepted diagnostic category. Psychiatric subjects should be described and/or selected, not in terms of a single (questionable) criterion, but in terms of all the pertinent physical and psychosocial variables. The total population must be described along all main ordinates before it can be determined whether a sample is truly representative.

The age and sex of the patient are examples of attributes which are not directly a part of the pathological picture.<sup>3</sup> Because of the obvious pertinence of these two physical factors they are almost invariably included in describing psychiatric subjects. Other physical factors, equally pertinent, are usually neglected. In a recent article,<sup>4</sup> the writer and co-workers reported failure to confirm the findings of testicular defects in schizophrenics as reported by Hemphill, Riese and Taylor. It is known that nutritional status is related to testicular structure and function. Thus, in current studies comparing schizophrenics to "normals," one must have adequate description along this segment of the physical parameter. If the hospital diet had led to nutritional deficiencies which affected the testicles, one would have to know this in order to determine whether any differences found between the two groups were attributes of schizophrenic vs. "normal" groups or nutritionally-deficient vs. nutritionally-adequate groups. With the related physical factors adequately described and controlled, the conclusions are much more likely to be both reliable and valid.

A real problem exists as to what should be included in an adequate physical description. Certainly all such physical factors as have been definitely shown to bear some relationship to the condition being studied must be included. As many as possible of other physical factors which are suspected of such a relationship should also be described. Needless to say, such description should be as uniform and complete as possible.

This same procedure should be followed with respect to psychosocial factors. Uncertainty as to which elements of the psychosocial parameter to include, or how to describe them, has led to



many debatable and contradictory findings. For example, differences in discharge rates between state hospitals and certain private sanatoria may be due not only (if at all) to therapeutic orientation, but to the ability and interest of the patients' families in maintaining the patients at home. Unless this situation is described, the question remains unanswered. Such examples could be endlessly multiplied. Even within a single culture the mores of various groups differ so widely that if all, or a majority of, the subjects are drawn from one such group it is difficult to avoid attributing universality to "pathological manifestations" which are really only attributes of a particular type of family or societal structure.

It is not essential that the sample represent these physical or psychosocial factors proportionately as they exist in the total population, but there must be sufficient representation so that analysis of variants can determine what is and what is not a related attribute of the group being studied. It may well be argued that a method of sample selection which requires the description of even one total hospital population in respect to all probably pertinent variables is impractical because of limitations of time and personnel. Certainly it is not a task to be undertaken lightly; but in view of the effort currently devoted to psychiatric research it is by no means prohibitive, and the "total" population need not be studied at one time. Any institution which intends to carry out intensive or extensive research on a particular group of patients must select the sample to be studied by such a procedure if results are to have applicability to the nonsample part of the population. Results cannot be validated or reliability tested by other investigators unless this is done. Nor, more importantly, can samples of related but different populations be compared to demonstrate the "universality" of the conclusions or findings. The application of this method to the selection of a sample of chronic schizophrenics has been made at the Rockland State Hospital Research Facility.<sup>6</sup>

It is perhaps well to pause at this point and dispel the myth of randomization. The view is still prevalent in some quarters that if you "grab without looking," your sample—by some statistical magic—will be representative. It should be clearly understood that random selection is most effective after accounting for all the *known* and suspected variables. Random selection is then of use in helping to eliminate any systematic bias in the *unknown* variables. Public opinion polls, for example, first stratify the pop-



ulation according to factors which are known to be related to particular attitudes being studied. Only within such stratified layers where known variables are already accounted for, is there possible the best application of the techniques of random selection.

The possibility of doing research in a less elaborate setting is not precluded if all these conditions cannot be met, but it does place very definite obligations on researchers who are working on samples of patients not selected in this manner. The pertinent variables must still be systematically described so that such data may be evaluated in respect to variables which could not be controlled or analyzed. Further, the researcher should be most diffident about claiming universality for his conclusions, since he has no way of evaluating how representative of the total population his particular sample is.

The closer the description of such a group of patients is to an unqualified "these 26 schizophrenics," the more useless it is to other investigators now or in the future. The principle of including an anamnesis of each case used in the study is highly laudable. If it could be done in a complete and systematic manner, important and extensive studies would not be nullified or questioned by the finding or conjecture of new related variables which the original researcher described but could not evaluate. The problem remains to find the best method of selecting a sample of patients by the researcher who does not have available the facilities for selecting a sample fully representative of some larger aggregate and who is aware that he must describe those subjects that he uses along the important parameters.

Since the relatively small number of cases likely to be at his disposal are prohibitive of co-variant analysis of all factors involved, it is strongly recommended that such researches be done on as homogeneous a group as possible. The investigator in any case will not be able to claim representativeness for his sample. He actually has more chance of unearthing reliable and valid findings and making important generalizations if he keeps the number of variables as limited as possible. Practical considerations will, in any case, limit the number and variety of patients amenable to testing. In addition, the nature of the attribute or the procedure being investigated will enter as a determinant of which patients are to be studied. A fuller illustration of this technique is given elsewhere.<sup>6</sup>



The nature and purpose of the investigation determine the criteria. To illustrate this, if the research were concerned with certain biochemical measures in psychotic, as contrasted with non-psychotic, pregnant women, the criteria for admission to the test population might be:

1. Age. Only females between the ages of 25 and 35 would be studied—in order to eliminate the possibility of late menarchus or early menopause.

2. Health. The subjects should have no disease or anomalies of metabolism which are related to the biochemical function in question other than the pregnancy.

3. Primiparity. Since the effect of previous gravidity is unknown, only subjects pregnant for the first time would be included.

4. Nutritional status. Since the biochemical function might be dependent on nutrition, all subjects should be adequately nourished.

5. Attitude toward pregnancy. Since emotional factors may influence the biochemical levels in question, subjects should be drawn from social groups and families having the same attitude and education in respect to pregnancy.

By limiting the number of variables it becomes much more probable that other investigators could repeat the experiment with similar results. Further, other investigators could extend the universality of the results by changing one of the population criteria. The experiment might be repeated on multiparous instead of primiparous subjects.

The entire population of such patients available should be surveyed and described before a sample is selected. Remaining variables which are felt to be related should be included in a manner that will permit their statistical evaluation. If there are insufficient numbers, either the group should be further restricted to make the population more homogeneous, or if this would limit the total population too much, note should be made of these factors for each subject and data presented in such manner that the distribution can be determined. If it is felt that all related variables have been either accounted for or are contained in the criteria for population membership, random selection of the sample is then in order.

Once the selection of the sample has been completed, there may be other practical considerations. If the granting of permits by



the family is required; if a certain degree of docility of the patients is essential because the tests require co-operation; or if other such limiting factors exist, a new problem arises. The exigency can be avoided, of course, if these requirements are included as criteria for population membership. At times it is necessary to eliminate subjects after the sample has been selected. The characteristics of these subjects and the reason for their elimination as samples should always be noted and included in the final presentation in order to provide the data with maximum usefulness for other investigators.

### COMPARABILITY

Once a test sample has been demonstrated to be representative, the next step is to compare it with other samples from the same or different populations. There exist three major methods of comparing: the intra-individual, the intragroup, and the intergroup methods. Each of these serves a different purpose and considerable difficulty can arise if a method of comparison is used which is unsuitable. The intra-individual method is suitable only for testing reversible procedures; the intragroup method is suitable for testing either reversible or irreversible procedures, and the intergroup method is suitable only for describing properties, characteristics, or attributes of one group in contrast to those of another group.

*Intra-individual Comparisons.* When the number of subjects to be tested is small and the number of variables is either unknown or numerous, the intra-individual comparison is the method of choice for evaluating a reversible procedure. Since the subject acts as his own control, the unknown variables, although they still remain unknown, can be regarded as relatively constant. If the experimental design is adequate, the effect of a particular process or procedure on a particular group can be measured.

An example of this is an actual experiment in which the question asked was whether and to what degree dibenamine influences catalepsy in catatonic patients.<sup>7</sup> Only nine such patients could be found in the 2,500-bed Veterans Administration Hospital, Lyons, N. J., in whom the degree of catalepsy satisfied the criteria and the variables relating to the occurrence of catalepsy were unknown. It is obvious that dividing the patients into three "simultaneous" groups to compare the effects of dibenamine, sodium amytal and



sterile saline would be most inconclusive because of the small number of patients in each group. If all nine patients were simultaneously tested on saline, subsequently on sodium amytal and still later on dibenamine, there would exist the possibility that any changes which were noted might be related to such factors as increased contact and stimulation not deriving directly from the drugs themselves, but to other factors which were present on one day of testing and not on another. The nine patients were, therefore, divided into three groups of three subjects.

In the first period of testing (which extended over several days) three of the patients were given saline, three amytal and three dibenamine. At the second time of testing, after a lapse of two weeks, the group which had received the saline now received amytal; the group which had received amytal now received dibenamine, and the group which had received dibenamine now received saline. Again, after a lapse of two weeks, the third test period was instituted. Those patients who had received saline and amytal now received dibenamine; those who had received amytal and dibenamine now received saline, and those who had received dibenamine and saline now received amytal.

Had all the nine patients on any test period shown similar changes one would have had to discount the effect of the particular procedure. Or had all the patients shown progressive changes regardless of the order of the tests from the first to the third test period, it would have been obvious that factors other than the injections were operative. Further, had any one of the injections brought about major irreversible changes this too would have been revealed. Had this last possibility been realized, i. e., if an irreversible change had been effected, the results, although stimulating, would have been inconclusive since the method of comparison would have been inadequate to determine whether or not this irreversible change was really due to the injection.

Unfortunately the intra-individual method is too frequently used in evaluating irreversible procedures such as prefrontal lobotomies or psychotherapy. A particular patient, subsequently lobotomized, who did not previously respond to "total push therapy" or to the more frequent "custodial-care therapy" in use at many hospitals, may achieve a recovery following lobotomy. This does not demonstrate that the operation was the necessary cause of the improvement. Similarly, the fact that a formerly impotent patient



achieves potency after four years of psychotherapy does not of itself demonstrate the efficacy of psychotherapy in effecting potency. In the case of lobotomy, any number of unknown variables may have been at work which were not directly related to the operative procedure. Shifting the patient from a back ward to a pre-lobotomy set-up with increased attention and an air of expectant optimism, or the subsequent post-lobotomy "re-education" process are uncontrolled variables in the case of intra-individual comparisons. The implicit comparison of these patients with others not so treated assumes either intra- or inter-group comparison. Because it is not done systematically or with awareness, it is the poorest type of control. Further, this is no longer an intra-individual control.

Similarly, the fact that a person is concerned enough about his neurotic condition to seek and continue to pay for psychotherapy over a period of years may introduce a selective factor. The willingness to undergo such treatment may augur a high capacity for self-recovery, and the relief from the neurotic symptoms might well have occurred with or without treatment. The fact that the subject may have possessed the neurotic trait for years previous to treatment is not conclusive, since the fact that he finally went for therapy may indicate that a new factor had entered. Oddly enough, the only convincing demonstrations, with intra-individual control design, of the effects of therapy are when the patients relapse into their original illnesses after therapy is discontinued. Comparisons of patients undergoing treatment, with those not receiving treatment, immediately shifts one to discussions of intra-group or intergroup comparisons.

In view of practical considerations, compromises with adequate research design are sometimes necessary. The practice of utilizing intra-individual control technique with a so-called "dry run" has had a recent vogue. Prior to carrying out an irreversible procedure, the conditions of the experiment are simulated except for the crucial procedure itself (e. g., lobotomy) and response to this "dry run" is accepted as an adequate control. It can only be re-emphasized that intra-individual controls are never completely satisfactory for irreversible procedures. Although this technique is a refinement which does possess merit, its use should be restricted to cases where more suitable control design is not possible, and



conclusions from this method can be accepted only tentatively until data provided by more suitable controls are obtainable.

*Intragroup Comparison.* This is the method par excellence for evaluating processes and procedures. Full realization of the extent to which intragroup comparisons can be made and their vigorous application would clarify many disputed areas in psychiatry.

Before discussing *intragroup* controls it is well to point out that *intergroup* comparisons are never suitable for the evaluation of procedures, although, knowingly or unknowingly, they are often used for this purpose. The first and by long odds the most common mistake is to assume that individuals belong to the same group (i. e., are intragroup members) when they have only a portion of related attributes in common. Frequently a group, equated as to pathological symptoms, is then divided for the purpose of intragroup comparison in such a way that physical or bio-social aspects are entirely unequal. If determining variables exist in either of these latter two parameters, unwarranted effects are attributed to the procedure being evaluated.

Examples are manifold. Interest of the family in a patient, for instance, not only has bearing on the patient's own emotional response but may determine whether placement outside the hospital is possible when a certain degree of social recovery has been achieved. If the procedure being tested is prefrontal lobotomy, a selection of patients is ordinarily obtained in whom pathological symptoms are roughly equivalent. In testing therapeutic effectiveness, these patients *cannot* then be divided so that those for whom permits for operation are not obtainable are used as controls for those for whom the necessary operative permits are obtained. It would be highly probable that those families who granted operative permits had considerably more interest in their patients than those who either failed to respond or refused permits. Discharge from the hospital might then be dependent on factors unrelated to the operative procedure and thus produce a false impression of the effects of operation. In actuality, this procedure is then no longer an intra- but an inter-group comparison between one class of patients in whom operative permits are obtainable and another class where they are not. The attribute of "being discharged from the hospital" is contrasted in the two groups, and no final data about the therapeutic effect of lobotomy are being provided, although the first group receives the operation and the second does not.



Unless all the facets of description are considered, errors will continue to abound. What was intended as an intragroup control design, adequate to evaluate a procedure, may otherwise, without the experimenter's awareness, become an intergroup comparison. The establishment of attributes may be mistaken for demonstration of the effectiveness of a procedure.

It is extremely unlikely that a population of individuals can be divided into two, three, or more groups with exactly equivalent distribution of known or possible related variables in all the areas of description for each subject. In other words, matched controls are rarely available, and, for that matter, are an unnecessary refinement. The sole requisite is that an adequate representation of each of the variables be present in each of the subgroups so that analysis of the influence of a particular variable is possible.

When a matter such as oral dependency, Oedipal fixation, slum environment or similar process is the subject of investigation, the intragroup may include not only all types of mental disease but a large population of "normals." As long as description is adequate in all known respects, and as long as test and control groups contain sufficient numbers of subjects for statistical evaluation of the variables, no limit exists to the number or kinds of members of the "intragroup."

As with procedures of shorter duration, the *intergroup* comparison is unsuitable for evaluating these long-duration irreversible processes, since the sole function of intergroup comparisons is to characterize or describe the properties or attributes of the groups themselves. To demonstrate that schizophrenics are fixated at the narcissistic level or that they come from families with a particular social organization, carries entirely different implications than saying that a narcissistic fixation or a particular familial organization has some causal or influencing effect on schizophrenia. Narcissistic fixation, familial organization, or what you will, may be ineffectual and nonoperative as a procedure or process and yet be perfectly valid as a characteristic, property, or attribute.

Failure to recognize this distinction, in respect to these more extended attributes or processes, has again resulted in attributing functional effectiveness to factors or events which possess validity only as attributes. Narcissistic fixation or familial organization may be investigated either as an attribute or as an effective pro-



cess. Intergroup controls are necessary in the former case and intragroup controls in the latter case.

Whiteness and a certain degree of coldness can both be shown to be attributes of snow. By intergroup comparison it can be demonstrated that these attributes of (the class) snow do not occur in (the class) rain. Cold as a procedure (i. e., making the rain colder) is one of the effective and essential procedures or processes in the creation of snow. White, on the other hand, as a procedure (i. e., making rain white, perhaps by adding some chemical) is meaningless and non-essential in the creation of snow. Thus, although both whiteness and coldness are real properties of snow, only the cold is an effective agent in the process of converting water into snow.

Only intragroup comparison enables one to evaluate the effectiveness of such a procedure, in which case two samples are drawn from a "population" of water. Snow formation is induced or aided in the sample made colder. "Whitening" a sample has no effect on snow formation.

When the experiment is designed to evaluate a process or procedure that has occurred in the past, a real problem exists. For instance, the role of parental rejection as an *effective* factor in the etiology of schizophrenia may be the subject of investigation. How to determine the degree to which an attribute is possessed by groups of schizophrenics in contrast to other groups, will be discussed shortly under "intergroup comparison." How to determine whether a factor has been effective is not always possible. Ideally, one should take an adequate population in which all other factors known or suspected of causing schizophrenia are equated sufficiently for statistical analysis and, then, by random selection, have half of the parents "reject" their children. In addition to the need for then following the samples throughout their entire lives—and even providing there existed good operational definitions of "reject" and assuming that all the parents so selected would comply by "rejecting" at request—one could then conclude only that parental rejection was involved in the causal or effective chain, but was not necessarily the sole or direct "cause." To circumvent these almost impossible conditions, it is common practice to attempt evaluation of the extent to which a process is an effective cause in a *post hoc* manner.



To determine whether schizophrenics have a higher rate of parental rejection than non-schizophrenics neither proves nor disproves the role of a parental rejection as an effective agent. It may, for instance, be that schizophrenic children are recognized (albeit unconsciously) as being unhealthy, unlovable, difficult, odd, etc., and this results in the normal, healthy parent "rejecting" them. In this case the procedure of rejection would be resultant rather than effective.

Is there then any way in which an effective (causal) role can be demonstrated in this case? The answer to this is a matter of how the question is asked. If even one case of schizophrenia can be found in which the parents were nonrejecting, we can conclude that the process is not either the sole or a necessary factor in the etiology of schizophrenia. If no case of parental rejection is found among the schizophrenics we cannot conclude that it is not a "cause" but only that it is not an effective process in the sample and population studied. If, as is more likely to be the case, the schizophrenic group may possess an attribute in a significantly higher degree than the control sample, we could not determine its etiological effectiveness without other knowledge.

The "joker" in the pack is that there is no way, in this illustration, of controlling or recognizing the factors which may bring about a selective bias in those cases where the parents do reject the children. It may be, as mentioned, that the schizophrenia in the children brings about rejection. It may be that rejecting parents have a low capacity for emotional response and that it is this, or some other "correlated" but dynamically different factor rather than "rejection," which is effective. Unless selective bias can be controlled or known, we can determine only attributes and cannot evaluate effectiveness of procedures or processes.

In other cases, such studies are possible. Bender, Goldfarb and others have suggested that institutional upbringing is a factor in the "creation" of psychopaths. An adequate intragroup population can be reconstructed. Let us, for instance, set criteria for population membership as follows:

1. Only children, from white, native born, Protestant, middle income families with no close relatives other than parents.
2. All children born of mothers free of serious illness or nutritional deficiencies during pregnancy and with uncomplicated labor.
3. All members of population born within a six-month period.



4. Either to be controlled by criteria of admission to the population or by adequate sample for statistical analysis are the following: (a) sex, (b) medical illness, (c) reason for institutionalization. It may be expedient to use as population criteria only those children whose placement is necessary because of the accidental deaths of both parents.

The test group might consist of children raised in a representative sample of institutions and, as comparable control groups, children raised in foster-homes and children raised in their own homes (where both parents are alive). Care would have to be exercised, so that a selective factor was not involved in the choice of children for foster-homes both because the foster-home-placed group might possess some essential attribute (other than the foster-home placement) and also because if this were the case, the institutional population would then be depleted of this factor and a selective bias introduced in comparison with the other control group.

If the experimental design were adequate, a significant difference in the rates of such institutionalized children who became psychopaths would then lead one to believe that some factor was operative in the process of institutional upbringing that resulted in an increased incidence of psychopathic personality.

This type of conclusion leads to one final important point about the nature of processes or procedures: namely, determining the limits or borders of the process. It is extremely easy to slip into the error of attributing effectiveness to the most obvious feature of the process when this is not necessarily the case. What specific process in the larger over-all process was effective in producing psychopathy cannot be determined without a new investigation. To cite a previous example, it may not be the severing of the frontal lobes, but some other factor in the process of lobotomy that effects improvement. The degree to which the effective process should be isolated and identified depends entirely upon the purpose of the investigation.

For clinical therapeutic purposes, an "extended" process may be perfectly adequate. For other purposes, knowledge of the most minute limits of the procedure is required.

*Intergroup Controls.* These are correctly used only to identify the attributes or properties of a particular group. Further, they are the only legitimate means of identifying such properties or attributes. The permissible variations in the size and variety of the



group have sometimes beclouded the fact that this particular design must be so used. In addition, the necessary control group is frequently assumed instead of being made explicit.

Suppose that we wish to investigate whether a particular attribute exists in all hospitalized patients. The sample, as has previously been pointed out, must be representative of the group it is taken to represent, so that all types of hospitalized individuals would have to be included. If such an attribute were found, it might be desirable to know if this attribute were unique in these hospitalized subjects. It cannot be assumed that this is the case without actual investigation. The attribute must then be searched for in a control group of non-hospitalized individuals. The control group of non-hospitalized individuals may be a comparable sample of *all* non-hospitalized individuals, all non-hospitalized individuals in the same community, all non-hospitalized individuals who are also not clinic patients or in jail or in the county poorhouse. The criteria for membership in the control group should be just as explicitly determined and stated as for membership in the test group.

As another example, the determination that schizophrenics who are discharged from the hospital, in contrast to those not so discharged, are those who have a particular type of endocrine organization is a legitimate function of intergroup control design. Again it should be pointed out that this in no way evaluates the effect of the endocrine system on the course of schizophrenia. This same problem could also be expressed in terms of an intergroup comparison between schizophrenics with one type of endocrine organization and those not having that type of organization, with "eventually being discharged from the hospital" as the attribute. The same experiment, however, cannot be used, since adequate and representative samples might differ considerably in the two groups. Similarly, intragroup comparisons which test a procedure cannot be automatically assumed to produce adequate samples or data for attribute analysis. Entirely different sample selection criteria may be necessary to demonstrate attribute belongingness.

There exist various types of intergroup controls. Schizophrenics may be contrasted with other types of mentally ill patients (pathological-pathological); or one type of schizophrenic (hospitalized) may be contrasted with another type of schizophrenic (non-hospitalized). This is also another example of the pathological-patho-



logical control. Schizophrenics may be contrasted with individuals not known to have mental disease (pathological-"normal"). "Normal" individuals possessing particular attributes may be compared to "normal" individuals not having these attributes (an example of "normal"- "normal" control). In theory an attribute cannot be assigned exclusively to a particular group unless all conceivable other groups have been tested. In practice, of course, this cannot be done, so that in this case the exclusiveness of an attribute is always relative and never absolute. It is also true that the universality of an attribute in a particular group can only be relatively demonstrated, since other schizophrenics under other conditions (of climate, diet, physical or psychosocial conditions) might not possess the attribute. If, however, the main parameters previously discussed are adequately described and the controls are adequate, the value of the work will not be nullified by findings of deviations under other conditions.

It will be noted that the word "normal" has always been enclosed in quotation marks here, since the meaning of this word in psychiatric research requires detailed examination. This has been the subject of a separate paper which is at present in preparation. The obvious problem resulting is how to select a representative sample of a "normal" population when the attributes of the total aggregate which the sample is to represent are not known. This, however, does not constitute a real problem if the properties or procedures investigated are in respect to a particular pathological group whose attributes can be determined or at least defined. One could speak with reliability of the attributes of schizophrenics hospitalized in Rockland State Hospital at a particular period (approximately 4,000 patients). To determine even the simplest attributes of the non-hospitalized population in the New York area from which these patients are drawn would be fantastically difficult (over eight million persons).

This means that representativeness can be determined for the test group but not for the control groups. Since the control groups are selected on the basis of comparability to the test group in respect to extra-clinical attributes (physical and psychosocial) it would be extremely unlikely in any case that such a group would also be representative of the larger aggregate from which it was drawn. In special cases it is sometimes possible to develop controls which are both comparable to the test group and representa-



tive of the larger aggregate from which they themselves are drawn.\* For ordinary purposes, however, this is a wasteful and time-consuming procedure.

One final caution is offered, namely, that attributes of a group (whether pathological or normal) selected on the basis of their comparability to a particular test group cannot be used to provide even reliable observational data about the control group. For example, it may be found that a control group of manic-depressives selected on the basis of comparability to a test group of schizophrenics in respect to extra-clinical characteristics might all have hypervitaminosis Q. One could conclude nothing about the relationship of vitamin Q to manic-depressives since the sample observed was not known to be representative of the total population of manic-depressives. One would have to select a representative sample of manic-depressives and repeat all the foregoing procedures to determine the relationship of vitamin Q to the manic-depressive psychosis.

*"Observational" vs. "Experimental" data.* In accordance with Boirac's paradigm for the scientific method, the four stages of research consist of: (1) observation, (2) hypothesis, (3) experiment, (4) deduction and conclusions. The simple finding of relations is, at the first stage (observation), either for the purpose of conceptualizing the nature of the group or for evaluating the effectiveness of a procedure. Such findings of relatedness are the *beginning* of scientific knowledge and not the final product. The unfortunate tendency to accept the finding of such relations as "experimental" rather than "observational" data has curtailed many a potentially valuable piece of work. The elaborateness of methods whereby observational data are obtained does not for that reason make them experimental data.

As an example of this research error let us gratuitously assume that a sample of hospitalized schizophrenics have been shown to have vitamin Q levels below the established normal range. This of itself is purely observational and not experimental data, and no conclusions can be drawn as to the existence of vitamin Q deficiency, either as an attribute of schizophrenics or as to the role of

\*Representative samples of both groups are first selected. Then the comparable sample is selected from the control group on the basis of attributes within the test sample. The control sample thus obtained is then used to select patients from the test sample. At all stages representativeness of both groups must be maintained.



vitamin Q as a causal or determining factor in schizophrenia. It has been the discovery of such relationships and the acceptance of them as experimental data which has led to confusion.

After confirming the foregoing observation, the next step would be to hypothesize that vitamin Q deficiency is an attribute of schizophrenics in contrast to various control groups. The first control group used in the experiment might be one of nonhospitalized subjects not known to have any psychiatric disturbance and comparable in respect to extraclinical (physical and psychosocial) characteristics. The fact that none of such a control group have vitamin Q deficiency would constitute only a partial confirmation of the hypothesis. One would then set up a subhypothesis that vitamin Q deficiency was not related to mental disease in general, but limited to schizophrenia. The next control group might then constitute psychoneurotic subjects under treatment at an available clinic. The absence of vitamin Q deficiency in this control group would again be only a partial confirmation. The next subhypothesis might be that the vitamin Q deficiency was not an attribute of all hospitalized patients, but only of the schizophrenics. If it could then be demonstrated that hospitalized manic-depressives, alcoholics, arteriosclerotics and other groups did not suffer from vitamin Q deficiency a further partial confirmation would be at hand. The next subhypothesis might be that nonhospitalized schizophrenics also suffered from vitamin Q deficiency. (Note that this is an intergroup and not an intragroup comparison although the basic hypothesis is meant to refer to *all* schizophrenics.) If it could now be demonstrated that vitamin Q deficiency was equally prevalent in the non-hospitalized schizophrenics it might be reasonable to accept vitamin Q deficiency tentatively as an attribute of schizophrenics of the particular type studied.

One could definitely not draw conclusions in respect to vitamin Q as an etiological or causally related factor. The actual fact might be that a particular enzyme system was concerned as a causally related element in schizophrenia and that quite incidentally this enzyme disturbance resulted in vitamin Q deficiency which, of itself, had nothing whatsoever to do with schizophrenia. It would now be necessary, on the basis of the foregoing observation, to frame a hypothesis that vitamin Q deficiency was an etiological, precipitating, predisposing or perpetuating factor in schizophrenia and not a compensatory, resultant or incidental attribute. De-



pending upon the nature of the explicit hypothesis, an experiment would then be designed, using intragroup controls, in which procedures would be carried out relating to vitamin Q and its metabolism. The finding of negative results when the test group was given large amounts of vitamin Q in contrast to the control group would not by any means demonstrate that vitamin Q bore no causal relationship to schizophrenia. It might well be that vitamin Q was effective only when given in conjunction with potassium or some other agent. Regardless of how many negative demonstrations are obtained, there is never absolute evidence of the absence of a causal or effective relationship. Repeated failures to demonstrate effectiveness and satisfactory demonstration of different variables which fully account for the differences in behavior do, however, reduce the relative likeliness of the factor being an effective agent.

Because of the highly complex and constantly fluctuant behavior of organisms, even the foregoing method may prove to be only propaedeutic to developing methods for the selection of adequate samples and controls. Certainly much that is taken for granted in experiments in the physical sciences, because of the fundamental differences in the nature of the material being investigated, must be brought to light and re-examined in biological experiments. The formulation of adequate conceptual and methodological tools for the study of animate nature, and particularly biological organisms, has hardly begun.

#### SUMMARY

1. Sample selection methods developed in the physical sciences cannot be directly applied to the study of deviant behavior: Individual differences cannot be totally neglected; motility and fluctuations of function must be taken into account; since "pure" samples cannot be obtained, methods for studying "in context" must be developed; and finally, the classification of material, upon which all science is based, is so tentative as yet in psychiatry that efforts must be devoted to developing a more adequate taxonomy, and safeguards against error must be maintained until such classes have been substantially established.

2. Samples should be representative of the population from which they are selected. This requires description and representativeness in respect to *all* important attributes and not just the diagnostic category. Methods and illustrations of how this can be accomplished are given.



3. Sharp distinction must be made between research that determines attributes or properties of classes (types of patients) and that which evaluates the effects of particular procedures on these classes. Demonstration of the existence of an attribute is not proof that it is causally (etiologically or therapeutically) significant.

4. There are three major methods of comparing (or "controlling") test results, each of which has its particular application:

(a) Intra-individual controls are suitable for use when the test sample is small, the variables largely unknown and the procedure to be tested is reversible.

(b) Intragroup (within group) controls are the method of choice for evaluating procedures and the only method of investigating irreversible procedures.

(c) Intergroup (between group) controls cannot be used to determine the effectiveness of procedures but are properly used to elicit the attributes of the group.

5. The difference between "observational" and "experimental" data is discussed, with emphasis on the fact that elaborateness of equipment and procedure does not transform the observation into an experiment.

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## EDITORIAL COMMENT

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### TO YOUR VERY GOOD HEALTH

Don't stop us if you've heard this before; we think we have, too. We think we have heard it all before, and many times, too, in the days before, and in connection with, the Red Feather and the present country-wide community chest organizations for welfare agencies. But we should like to apply some observations that are by no means new to our voluntary health organizations—those dedicated to relief, prevention, education and research—as they are functioning today.

We, therefore, propose to discuss some aspects of our health groups' fund-raising organizations and functioning. We are not primarily, or even particularly, concerned here with the fellow who is always being asked to put his hand in his pocket to assist in the financing—although he serves very well indeed to illustrate. Our primary concern is with the health organizations themselves, the work they are doing, the educational task they are attempting, the general cause of a healthier America. We in psychiatry have a personal stake in the time and money and efforts we have invested in the National Association for Mental Health; and we have an important stake as citizens in a healthier nation generally. Besides our stakes as mental specialists and citizens, we have another as general medical people in the promotion of more healthful habits and more healthful ways of living.

We wonder if our presently discrete units in such fields as mental health, poliomyelitis and cancer are meeting our hopes and our intents in making our people happier and healthier. We wonder if they are functioning, not only for the best interests of those they serve, but for the best interests of themselves as organizations.

To spend a moment on the problem of contributions, we wonder if, through duplication of solicitation and multiplication of effort, we are not approaching the point of diminishing financial returns—if we have not, in fact, passed it. We wonder if, considering the health organizations as a whole, the multiplication of collecting, administering, technical and public relations staffs in half a dozen groups or more is not top-heavy and unduly expensive. We won-



der if—because as one solicitation follows another, the difficulty of obtaining contributions increases—we are not now compelled to spend more than should be necessary on the business of collecting, and so have less than we could well use for the actual work of our health programs. We wonder, too, if, with present methods, distribution of available funds is the best possible. When it comes to soliciting money, the first to come is not only the first served, he is likely to be the best served. If the tuberculosis and the heart associations come around first, they are likely to be served better than the cancer and mental health organizations coming later—and quite regardless of the relative needs of the groups. We suspect that if the various health associations could get together in something like community chest fashion, they might profit financially. We are perfectly aware, of course, that organizations who do not think so have blocked united fund drives in the past; we suspect conditions have now changed; and we think, even if they have not, that the time is past for selfishness!

We think some other than financial aspects are rather more important. If we fail to get funds we should have, or fail to make the best use of the funds we do get, we also fail to get all the co-operation we should have, or make the best use of the co-operation we do get. In any community, the numbers of the public-spirited who have both energy and ability to spare are limited. We think we are trying to spread too few of these people over too many organizations. If we round up some energetic organizers, good speakers and active students of their subject for the cancer organization or the mental health association, we may be depriving the tuberculosis and poliomyelitis groups of services which, in our particular community, they may need more. If we try to spread our few enthusiasts over several organizations, we are simply dividing membership time and interest to the point where no group at all will be served well.

This situation, we conceive, is also hampering our educational endeavors. The health crusader—in whatever specialty—must, among other things, employ established media for publicity, newspapers, radio and television, in any campaign for membership or public financial support. Any newspaper editor can pile a waste-basket high daily with publicity offerings in support of worthy causes. He can select a few—almost at random—for publication



with moderate space, or attempt to make bare mention of many; but a great many more will land inevitably in the yawning wastebasket. Groups with the best volunteers in the business of public relations, or with the best professional services, are likely to fare better in the scramble than the less well-served, quite regardless of the relative worth of their causes. The radio situation is parallel, with the radio program director often having to be even more selective in what he presents than is the news editor. And the business of commanding television attention may be more difficult still. We think this sort of thing means too little information, poor information, even misinformation, for the people we are trying to reach. We are failing to tell anything to a great many people and are failing to tell very much to a great many more.

Centralized handling of health educational material would, we think, get much more of it before the public—by avoiding editorial wastebaskets—and benefit the public health that much more. We think, too, that co-ordination of health association efforts should assure us of progress without relying on the adventitious circumstance which has provided major campaign impetus in the past; as, for instance that a president of the United States had been crippled by poliomyelitis; or, in a more circumscribed area, that a child with cerebral palsy, was able to dramatize the plight of other child victims by becoming an eminent medical specialist in his own disease. We should be intelligent enough to prepare ourselves, we think, without having to wait for eminent victims or exploits of personal heroism to dramatize any threat to health in general. With an alert, co-ordinated public health effort designed to cover the total field, we think we could combat the less dramatic, but no less real, among the health menaces more successfully.

Proper co-ordination could mend defenses which, like the 1940 Maginot Line, could not only be turned but have plain gaps in them. We cannot expect organizations formed and adapted to fight cancer and tuberculosis to meet a new and different menace (which might arise at any time through mutation of a virus or a bacterium) adapted to sweep around our flank like a tank column through Belgium. Or we cannot expect our present health education measures to meet currently-controlled dangers gone presently out of hand, as by sudden multiplication of penicillin-fast gonococcus or treponema pallidum. But with the health groups united



and prepared to act where needed, new menace would automatically bring new defense. And if some of our problems were suddenly solved; if, for instance, cancer, poliomyelitis or tuberculosis were suddenly to be disrated from the rank of killer to that of minor nuisance—and we know that while this is unlikely it is not inconceivable—effort and organization no longer needed for a specific purpose could be turned readily to another. With today's discrete organizations, a group with its special health problem neatly solved would be simply homeless, its further efforts wasted.

We think also that co-ordination of our efforts would do us, as specialists, the people we seek to interest as workers and organizers, and the public we seek to educate, more than a minimum of good. As it is, we are all too prone to attach disproportionate importance to our own fields. Medical people are human; and, if the legendary breakdown into right-eye and left-eye specialists ever could occur, we have no doubt they would battle bitterly over which was more important than the other. For our own sins, which are manifest and manifold, we may note that a recent medical writer has chosen *It's Not All in Your Mind* for his new book's title. However inescapably necessary extreme specialization may be, it is bad for the sense of proportion which is a basic objective of all good education, including our own; and it can be a source of wide distortion in any health campaign addressed to the public at large.

Those who have borne with us thus far are invited to draw their own blueprints. We haven't gone that far and don't intend to. We do think any such co-ordination or consolidation should not be controlled by professionals; and we think the work of organization will likely be a slow process—and maybe ought to be a slow process. We think the thing is vastly complicated also by the national organization of the health groups.

Many of the organizations now supported by community chest campaigns are strictly local to their own communities—most voluntary hospitals and settlement houses, for example. Many others, a YMCA, for instance, may be organized nationally but, in relation to community activities, supported strictly locally. The mental health, tuberculosis, cancer and other health groups are national associations. To federate or unite on a community basis, it might be necessary to federate or unite on a national basis; and we have already made note that this may be difficult. We know



of individual community amalgamations of two or more groups, in some cases apparently working well, in others abandoned after valiant attempts. And we are awaiting with interest the outcome of endeavors in some places to put present community chest and health organizations into consolidated "united funds." Perhaps if this sort of thing can be worked out here and there on a local basis, it will point the way to the general unification we have in mind.

Whatever we call it, and whether we retain temporarily or discard at once our separate organization titles, what we have in mind eventually is a community set-up in which all existing health organizations will function as united community associations, carrying on their present activities as sub-associations, committees of the main association, or subcommittees. It seems to us that there will be manifest present, and eventually great, advantages.

From the point of view of the mental health people, it is impossible to separate mental health from health in general. Factions among us have almost made a phrase of opprobrium of *mens sana in corpore sano*, using it as a reproach against proponents and opponents alike of organicism (whatever that means) as psychiatric theory. But in its original sense of healthy mind in healthy body, it represents a goal that we cannot well attain in fractions. A person is either healthy or unhealthy; why divide him into parts? The result is just as deplorable (and not vastly different) whether ill health is in a paralyzed limb, a deranged mind or a weakened heart. And we think we workers for health in one part or another, one limb or another, one function or another, would do well to recognize the reality and work for health as a whole.

We can see complications. Which tail is going to wag the dog? Or do we take turns? We see no reason for too great conflict on lines of specialization. It is true that we can always refer to the psychiatrist who misdiagnosed brucellosis as neurasthenia; but we also know of a cardiologist who diagnosed mitral stenosis as a cardiac neurosis. We think promoters of mental health ought to be able to work as well with other health groups as we can with ourselves, or as they sometimes do with themselves. We think mental health principles permeate other health problems all along the line; and other health principles *vice versa*; they permeate mental health problems all along the line—as any psychiatric social worker can stand up in meeting and loudly testify.



But if we see no reason for endless conflict, we see no reason either for anticipating a Swinburnesque path of co-operation lightened by the wine of optimism and strewn with thornless roses. We can see practical difficulties which will give people of the greatest goodwill the greatest trouble to work out. All the more reason, we think, for doing something about making a beginning. We know that both national and local attempts at this have failed before. We think they ought to be made again.



## BOOK REVIEWS

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**Practice of Psychiatry.** By WILLIAM S. SADLER, M. D. 1146 pages. Cloth. Mosby. St. Louis. 1953. Price \$15.00.

Dr. Sadler has already written two textbooks, namely, *Theory and Practice of Psychiatry* published in 1936 and *Modern Psychiatry* published in 1945, but he advises in his preface that the textbook reviewed here is not revised from other issues but is rewritten. In rewriting he has brought his work up to date, and he has added several new features, one of which, is his section dealing with "Attitudinal Pathoses" (pre-neurotic disorders).

The book has seven parts: Part I, General Psychiatric Consideration; Part II, The Pathoses; Part III, The Neuroses; Part IV, The Psychoses; Part V, Personality Disorders; Part VI, Psychosomatic Disease; and Part VII, Psychotherapy. In addition, the book has an appendix in which the history of the theories of the various schools of psychiatry is given; it has a glossary which is equivalent to a psychiatric dictionary; it has a good bibliography; and last, it has a very good index.

This textbook should be very useful to students and general practitioners. It is a good textbook. It does have some defects, however. One regrets that the author has tried to coin new words and has classified and described mental illnesses according to his own style. In addition, he does not follow the new American Psychiatric Association classification of mental diseases, and it is not even mentioned in his book. At best, psychiatry is confusing to the student, and textbooks which vary too much from accepted standards do not improve the confusion.

**Psychiatry To-day.** By DAVID STAFFORD-CLARK. 304 pages. Paper. Pelican Books. London. Penguin Books. Baltimore. 1952. Price 65 cents.

To anyone in the fields allied to psychiatry this book will prove to be one of the best possible investments. While written for the intelligent layman, the extremely low price and the soundness and scope of the information contained open many possibilities for the book's utilization as a teaching tool. The format is rather monotonous, as is to be expected in a pocket-sized edition, but this is a minor matter. The coverage of the subject is very comprehensive, but better for the functional than organic psychoses. Technical and factual information is well presented—the essential data are given and dullness is to a large extent avoided. The author retains an objective attitude in his writing, though the general approach is essentially orthodox. The fact that the book was written in England in no way detracts from its value in this country—in fact, at times this reviewer thought it an advantage.



**The Second Sex.** By SIMONE DE BEAUVOIR. 732 pages. Cloth. Knopf. New York. 1953. Price \$10.00.

The widely publicized book of the female French existentialist is best characterized by two rhetorical questions: "How naïve can one be?" and "Isn't it probable that if someone dared today to revive du Maurier's writings on Trilby-Svengali (1894), he would be laughed out of literary existence?" Still, Simone de Beauvoir's thick volume is but a revival of the old feminist literature of the 60's, 70's and 80's of the last century, making out of man the malefactor who subjugates the "second sex" à la Svengali. In Mme. de Beauvoir's case, Svengali is social custom and a mysterious fear of "the Other," whatever that may mean. Save for a few existentialist and Marxist trimmings (the latter gallantly overlooked by the host of enthusiastic reviewers), this anachronistic book could have been written nearly a century ago.

The sober fact is that what the author has to say in 732 pages, can be condensed into a few words: Man enslaves woman. Everything else in the volume is but wrapping paper, including amateurishly used biological, historical, literary, and sociological material. The book is boring, loquacious, repetitive, and especially quarrelsome, even to the point of mildly suggesting mild paranoid ideas. The author is pitifully disoriented about modern psychiatric-psychoanalytic findings. Her main authority is Stekel; when she refers to Helene Deutsch, she mostly misunderstands; her polemic with Freud is based on ignorance of his later findings on pre-Oedipality.

Time and again, the sex act is described as cruel aggression against poor woman; Mme. de Beauvoir completely ignores the fact of neurotic passivity in men; as Karl Menninger aptly remarks, "Every psychiatrist sees a dozen women complain of the passivity, dependence, and/or impotence of their husbands to one who complains of his ruthlessness."

The book is impressive only in its mass of misunderstandings. To name a few: The author misunderstands the oral phase; the Oedipal phase is changed to unrecognizability; the difference between clitoridean and vaginal orgasms (though mentioned) is misinterpreted; Lesbianism and prostitution are misconceived—in popular terms; the whole problem of neurotic fears is widely distorted.

More dangerous is complete misunderstanding of motherhood: "There is nothing natural about maternal love. They [mothers] are permitted to play with toys of flesh and blood" (p. 523).

And the solution during the transitional period to a happier state? Although the author is unclear on that point, one gathers the impression that some kind of promiscuity is half-suggested; some passages in the last chapter, especially on pages 686 and 687, give this impression, when the situation is regretfully noted that "to enjoy the relaxation and diversion provided by agreeable sexual adventures" is not so easy for the woman.



"Her situation in this respect is not equivalent to man's." Or, if the demand of some women "for brothels for females," staffed with "taxi-boys," is discussed, it ends up with the statement, "At any rate, this resource is unavailable."

Ironically, where the author has a case, she does not see it, or is uninformed about scientific findings. There is no doubt that the typical man has a supercilious attitude toward woman, based on the narcissistic defeat of having been, once upon a baby-time, completely dependent on a woman. Bergler described in *The Basic Neurosis* the compensatory "hoax of the He-Man," and showed that by using the "unconscious repetition compulsion" (Freud), denoting active repetition of passively endured experiences to restore the lesion in his narcissism, the boy reverses the roles of active mother and passive child. By unconsciously identifying breast and penis, vagina and mouth, milk with urine (later sperm), the man acts in intercourse as the active "mother," reducing the woman to the baby—the image of his own infantile self. This is also the reason why man calls woman—"baby." This compensatory attitude unconsciously colors man's whole attitude toward woman. Finally, all the Grand Guignol of infantile fears (enshrined in the unconscious) is counteracted by proving to himself that "woman is too weak to be dangerous." Here is the real case that the author of *The Second Sex* fails to see.

To sum up: *The Second Sex* is scientifically a complete nonentity, based on ignorance and prejudice. However, the combination of naïve popularization plus sex, seems irresistible for immature critics and—readers.

**Psychological Problems of Cerebral Palsy.** 79 pages. Paper. Published by The Easter Seal Society. Chicago. 1952. Price \$1.25.

This publication is the proceedings of a symposium on cerebral palsy sponsored on August 20, 1951 by the National Society for Crippled Children and Adults, and the Division of School Psychologists of the American Psychological Association. A well-rounded selection of papers by authorities in the medical, psychological, and educational aspects of cerebral palsy is included. Research material is presented, and discussions of each paper are also included. The first of the five papers comprising this symposium is on the anatomical facts related to spasticity, by Douglas Buchanan. Charles Strother, professor of clinical psychology, University of Washington, presents the next paper on the psychological aspects of cerebral palsy; Harry Bice presents "Group Counseling with Parents of the Cerebral Palsied"; Edgar Doll's paper is on the "Distinction between Neurophrenia and Cerebral Palsy"; and the final paper is on "Educational and Vocational Planning for the Cerebral Palsied Child" by T. Ernest Newland. A summary by Dr. Doll rounds out the symposium. The papers and the discussions are, for the most part, well presented, and this publication is recommended for those interested in the area of cerebral palsy.



**Psychology of Physical Illness.** Psychiatry Applied to Medicine, Surgery and the Specialties. Leopold Bellak, M. D., editor. 236 pages. Cloth. Grune & Stratton. New York. 1952. Price \$5.50.

In his introduction the editor states, "We offer this book with the hope that we may contribute to a better medical practice—one which is more enjoyable for the doctor and more beneficial to the patient.

"The chapters of this book are so organized as to primarily present the psychological implications of the medical-surgical disorders of each field. Secondarily, the psychogenic aspects of somatic complaints are discussed for convenience of organization and because psychosomatic and somato-psychic problems often interact.

"Each chapter is written by authors with experience in both the medical-surgical specialty and psychiatry. By this means we hope to present not irrelevant theory, but practical useful data by men with real experience."

In most cases, neuropsychiatrists are well acquainted with emotional problems which are expressed in somatic symptoms, but such is not the case with most general practitioners and many specialists. The book, therefore, seems to be directed to these particular medical men. In it, psychiatric problems associated with internal medicine, surgery, obstetrics, gynecology, genito-urinary medicine, orthopedics, pediatrics, dermatology and dentistry are presented especially well. In addition, a chapter reminds the physician that his own personality is an important factor in therapy.

**Our Common Neurosis.** Notes on a Group Experiment. By CHARLES B. THOMPSON, M. D., and ALFREDA P. SILL. 208 pages. Cloth. Exposition. New York. 1952. Price \$3.50.

The late Dr. Trigant Burrow was probably one of the first to experiment with what is now called group therapy. Many of his opinions were molded by research projects such as has been recorded in this book by two of his co-workers. What Dr. Burrow called "phylobiology" refers to a study of the "whole" man, psychologically and physiologically, under the influences of society, with its customs, its teachings, its moral and social philosophies and its inconsistencies of behavior.

The co-authors state that each human being is abnormal in his individual manner and that every person suffers from a "common neurosis" created through social unrest, disguise, deceit and selfishness. "By turns aggressive and timid, but continually preoccupied with his own prestige, man is impelled to fight by an obsessive urge he has never tried to understand. A phylo-organismic interpretation of behavioral conflict demands that we abandon the solemn farce . . . and adopt an immediate, internal, societal approach to man's disordered behavior. It demands that we turn aside



from the fascination of this or that external circumstance, this or that moral judgment, and face human conflict as a problem internal to ourselves as a race or species."

The book contains 53 sketches and essays written about 1923 by students who became members of a research group and who, in their writings frankly expressed their own personal conflicts as they might do in what one now calls group therapy. The co-authors, Thompson and Sill, have spaced this material along with their own opinions in such a way that the book is interesting and very informative.

**Treatment of Mental Disorder.** By LEO ALEXANDER, M. D. 490 pages. Cloth. Saunders. Philadelphia. 1953. Price \$10.00.

Dr. Alexander is well known for his studies of neurophysiology and neuropathology and, more recently, for his work in psychiatry. He is now director, The Neurobiological Unit, Division of Psychiatric Research at Boston State Hospital.

Dr. Alexander credits the common forms of psychotherapy with many successes and, in his book, reviews and discusses these therapies but he calls special attention to the fact that "... a fourth group of psychiatric workers is starting to emerge and is approaching the problem from three angles; first, in a concern with the scientific investigations of the basic principles involved in the new methods with an attempt to understand them against the background of neurophysiologic knowledge, correlating them with the established facts and scientific principles of neurophysiology; second, in a study of the actual direct consequences of these methods on the patient in the light of our knowledge of the integration of higher cortical activity—for which I should like to use the term, *psychophysiology*, and third, in attempts to test and investigate the interrelations between these newly discovered psychophysiological phenomena and the body of psychodynamic knowledge. It is to these attempts that this book will be especially devoted."

In his somatopsychic or psychophysiological approach to the treatment of mental illness, the author relies heavily upon what he calls "the Funkenstein Test" to determine what type of physical therapy he is to use. This test was developed by Funkenstein and his co-workers in a study of the mental "patient's psychic and autonomic reaction to two drugs with opposing effects on the autonomic nervous system—*epinephrine*, which with its adrenergic effect may serve as a measure of sympathetic reactivity, and *mecholyl* (acetyl-beta-methylcholine, methacholine), which with its cholinergic effect may serve as a measure of parasympathetic reactivity, or rather as a counterbalance of sympathetic reactivity. In the test devised by Funkenstein and his co-workers for this purpose, he uses the systolic blood pressure as a measure of autonomic reactivity to each drug after the



basal blood pressure level has been established, determining the intensity of response and the ability to re-establish homeostasis."

It seems that the reactions to these drugs fall into six groups and that the type of reaction will predict the type of physical therapy which is best to use and the probable prognosis. The author has apparently used this method extensively, and he reports obtaining good results. In describing his methods, he includes brief case histories with graphs showing the "Funkenstein Test" reactions before and after treatment. The forms of physical treatment which he uses are, mainly, convulsive electric treatment, nonconvulsive electric treatment, electric stimulation, insulin shock and a combination of two or more.

This book will be especially valuable to those who are starting to use the various forms of physical therapy. The author describes the types of electric current, the various methods used and the equipment necessary. He spends several pages describing use of the Teiter equipment for nonconvulsive therapy.

In addition, Dr. Alexander describes the complications which may arise in the use of physical methods; discusses the neuropathological aspects; reviews his results and those of others who have used these forms of therapy; describes the role which the nurse must play; and reviews the treatment of alcoholism, drug intoxications, and organic cerebrospinal diseases.

**Social Treatment in Probation and Delinquency.** By PAULINE V. YOUNG, Ph.D. xxvi and 536 pages. Cloth. McGraw-Hill. New York. 1952. Price \$7.00.

This book will be found of primary interest to those in the fields of child welfare and sociology, rather than to those in psychiatric work. The sections dealing with such matters as the Rorschach Test are elementary in approach. A great deal of individual case data is included, and a very comprehensive survey of the field is given. The value of the book to social workers and child guidance workers should not be underestimated.

**Las Pruebas Proyectivas y el Conocimiento de la Personalidad Individual.** POR MIGUEL SIGUAN. 116 pages. Paper. Departments de Psicologia Experimental Instituto Luis Vives. Madrid. 1952. No price stated.

A psychologist in Spain offers a descriptive pamphlet on the Rorschach examination and Thematic Apperception Test. All of the work is a direct translation of source material. There is no indication that the tests are being used for experimental, standardization or diagnostic purposes in that country.



**Famine Disease in German Concentration Camps: Complications and Sequels.** Acta Psychiatrica et Neurologica Scandinavica; Supplementum 83. By PER HELWIG-LARSEN, HENRIK HOFFMEYER, JOERGEN KIELER, EIGIL HESS THAYSEN, JOERN HESS THAYSEN, PAUL THYGESEN, MUNKE HERTAL WULFF. 460 pages. Paper. Ejnar Munksgaard. Copenhagen. 1952. Price Dan. kr. 35.00.

The effects of prolonged starvation upon the human body and personality have been studied by many groups, but until the experiences of the last war there had not been a situation where effective research could be conducted. The condition of Danish internees was not typical of German concentration camp inmates, but this in no way invalidates the observations made in this book.

The chief difference to be found between the conditions in the German and Japanese prison camps was the fact that in the German camps the chief deficit was in *quantity* of food, while in the Japanese camps it was in *quality* of food. Thus, the cases of avitaminosis so prevalent in the Japanese camps were rare in the German camps—in all too many cases the internees in the German camps starved to death before the symptoms of avitaminosis had time to appear. During this starvation regime, acute psychiatric symptoms were a rarity—the usual effect being, rather, a complete dulling of the mental faculties.

The aftermath of this type of experience on the internees has been a very prevalent neurasthenic syndrome—occurring to greater or lesser degree in the majority of those interned. Psychoses following the experience were a rarity—there were few cases, even if those committing suicide are considered in the psychotic classification. The authors put forward their views well, but in no sense dogmatically; full recognition is given to the fact that the men making the study were not psychiatrists but medical doctors, who, through circumstances, were present at the time.

**The Origins of Intelligence in Children.** By JEAN PIAGET. xi and 419 pages. Cloth. International Universities Press. New York. 1952. Price \$6.00.

The work of Piaget is too well known to need further introduction. This book records his researches concerning the factors that originate intelligence in the child. Intelligence is held to be: "the development of an assimilatory activity whose functional laws are laid down as early as organic life and whose successive structures serving it as organs are elaborated by interaction between itself and the external environment." This is most definitely not a book for the casual reader—only a person deeply interested in the subject will have the tenacity to follow the author through the maze of his researches and thinking.



**Lives in Progress.** A Study of the Natural Growth of Personality. By ROBERT W. WHITE. v and 376 pages. Cloth. The Dryden Press. New York. 1952. Price \$2.90.

The author intends this book as a brief introduction to the field of personality. There is an attempt to understand and examine, by methods which are described, the life histories of three normal persons. The author first makes a short survey of the various theories which have contributed to our knowledge of personality—biological research, especially that in learning; dynamic psychology; and the social-cultural approach. In the case studies which follow there is constant interpretation of the life history and test data in terms of these various points of view, as well as generalizations about the behavior of man.

Intervening chapters are concerned with the methodology of the study, the effect of social forces upon the subjects' lives, and the biological roots of personality. When the three case histories have been discussed in detail, White then sets forth what he calls the psychodynamics of development. This is primarily a critical evaluation of the Freudian theory in terms of its utility in contributing to the understanding of the three individuals studied. The concluding chapter presents the author's thoughts on the process of natural growth. Here is stressed the fact that the individual responds selectively to the environment. He is active and cannot be considered a passive, helpless and static organism.

**How to Understand Propaganda.** By ALFRED M. LEE. xii and 281 pages. Cloth. Rinehart. New York. 1952. Price \$3.00.

The techniques employed in influencing people have been refined to an extraordinary degree. By turning the switch on a television set, one can see any number of devices used—be they to gain votes or to change the brand of your toothpaste. The author, in studying the subject of propaganda, has brought to the task a good knowledge of psychiatric concepts, which he utilizes when the occasion warrants it. It is interesting to note that this book, which deals with propaganda, could, because of the choice of subject matter, be accused of being "liberal" propaganda itself.

**The Lovers.** By KATHLEEN WINSOR. 362 pages. Cloth. Appleton-Century-Crofts. New York. 1952. Price \$3.50.

*The Lovers* consists of three novelettes. Each of the stories has a theme of love—love, in its most primitive form. To add intrigue, the author introduces symbolism and the supernatural. Why she bothered with the latter concepts, one will never know. She lacks ability for the abstract, has little imagination and underneath the verbiage it's still pretty much of the same *Amber*.



**Navaho Religion.** A Study of Symbolism. By GLADYS A. REICHARD. Bollingen Series XVIII. 2 Vols., 800 pages, including index. Cloth. Pantheon Books. New York. 1950. Price \$7.50.

Students of abnormal behavior are past the stage when they have to be converted to the tremendously suggestive value of ethnographic data. The many bridges built by Freud, Róheim, Kardiner, Erikson, Devereaux and others have made the communication between dynamic psychiatry and cultural anthropology easy and fruitful. Thus, it is only too natural to look at every new collection of anthropological field data with reference to their potential value for research and theorizing in psychiatry.

Viewed in this light, Gladys Reichard's two-volume study of Navaho religion is somewhat frustrating. It contains enough insights into Navaho attitudes toward death and human destiny, disease, diagnosis and therapy, supernatural monsters and protectors, sex morals and the concept of honor, to make one want to learn more about the complex inner life of this human group. The author, who is a life-long student of the Navaho and could be presumed to have a wealth of first-hand observations, never goes beyond tantalizingly brief references to specific cases, and thus leaves one with a feeling of dissatisfaction. In a sense, this work could be considered a collection of leads for anyone with the desire and the means to do an intensive study in this largest and culturally best preserved of Indian groups.

The Bollingen Series to which this book belongs is usually associated in our minds with the Jungian school of psychology. Professor Reichard's dryly academic study bears no trace of this school's impact.

**Personal and Social Adjustment.** By WAYLAND F. VAUGHAN. 578 pages. Cloth. Odyssey Press. New York. 1952. Price \$4.25.

This text, the author asserts, differs from other textbooks on mental hygiene in that it deals chiefly with normal people rather than abnormal. It is oriented around the concept that mental disorders are essentially disturbances in social relations. It tries to show how love and hate affect our human relationships for better or worse.

This text provides a rather wide range of topics covering diagnostic and therapeutic techniques, and discusses the contributions of Horney, Adler, Jung, Freud and others. In addition there are excellent presentations of the history of psychotherapy; the techniques used by psychoanalysts, projective tests "as x-ray procedures," the role of semanticists, the contributions of Alcoholics Anonymous, accomplishments in psychodrama, and discussions of the mental health problems of infancy, childhood, adolescence, adulthood, middle age and old age.

This book is extremely easy to read, with its many illustrations, cartoons, and frequent use of humor, and it should provide an excellent college text for beginners in the study of mental hygiene.



**How I Cured My Ulcer.** By JOHN PARR. 153 pages. Cloth. Little, Brown. Boston. 1952. Price \$2.75.

One might say that the author is "scooping" the doctor and the authorized medical journals. He gives one the impression that he is so happy to have been relieved of his ulcer that he wants "the world to know." Perhaps one cannot blame him. At any rate, the author gives a somewhat tragic, yet amusing account, of his experiences in seeking a cure for his gastric ulcer. He tells of the various doctors (fictitious names are used) he consulted, their explanations and their methods of treatment. He states that he consulted a Dr. Spira who had concluded that it was not hydrochloric acid, etc., which caused ulcers but that they were due to a hypersecretion of bile. Because of this, the doctor gave him some alkalies to relieve his pain, but the special therapy was a fat-free diet. Milk, cream, fatty foods, etc., were all forbidden.

The author states that the doctor has proved this method of treatment to be the correct one and that articles written by the doctor will soon appear. Everyone hopes that all of this is true and that, at last, gastric and duodenal ulcers can be easily cured.

**Psychology in the Service of the School.** By M. F. CLEUGH. 183 pages. Cloth. Philosophical Library. New York. 1951. Price \$3.75.

This text is written for parents, teachers, welfare officers, probation officers and others interested in problems of childhood. There is a minimum of technical language and a large number of examples.

The author discusses in detail different types of children's problems, analyzes their causes, and makes suggestions for better understanding of the difficulties. Problems discussed include: judgments and misjudgments, meaning of maladjustment, fight and flight, handling of aggressive reactions, and handling of regressive reactions.

The text is well written but very superficial, even for a layman. The title of the book is misleading, in that school psychology, as we know it today in America, is a more highly developed procedure than this book might indicate.

**By the Waters of the Danube.** By ALEXANDRA ORME. 360 pages. Cloth. Duell, Sloan & Pearce. New York. 1951. Price \$3.50.

This novel is about Hungary and Poland in 1945, immediately after the end of World War II. A mass of frightened humanity, pressed into the Soviet orbit, is depicted; the tone is sometimes flippant, sometimes ideologically confused, frequently intermingled with grim humor. The author seems to describe her own experiences; she has no idea how a book is written, although sometimes she manages to convey a remarkable picture of human derelicts.



**History of American Psychology.** By A. A. ROBACK. 403 pages. Cloth. Library Publishers. New York. 1952. Price \$6.00.

This is probably the first popular-styled history of American psychology. It is, naturally, very factual and documented but it is also easy and pleasant reading. It is the type of book which will be very helpful to the student. It will be especially good for college libraries.

Part I begins with colonial days; follows through the periods when psychology is trying to be recognized as a separate entity in the world of science; describes the Scottish and the German influences and the gradual transition period during the 1880's.

Part II covers the subject, "Psychology Comes of Age." The new psychology, as Dr. Roback states, became a psychology of experimental methods of teaching; and became a specialty with a language of its own, divorced from religion and philosophy. This part of the book also gives brief but very informative and, at times, very amusing biographies of such men as William James, G. Stanley Hall, George Ladd, J. Mark Baldwin, J. McKeen Cattell, Edward B. Titchner and Hugo Münsterberg.

Part III describes and elaborates upon the various "schools" of psychology.

Finally, in Part IV, Dr. Roback looks to the future and to the phenomenal advance of American psychology.

**Marriage.** By KENNETH WALKER. 136 pages. Cloth. British Social Biology Council. Secker and Warburg. London. 1951. Price \$2.00.

This book is intended for both married and about-to-marry couples. It aims to provide information and guidance essential to building a successful marriage. There are such topics as: choice of a partner, courtship, preparation for marriage, sexuality in marriage, anatomy of the male and female sex organs, the nature of the sex act, difficulties arising on the wedding night, frequency of intercourse, and sexual needs of both partners.

In addition, there is a chapter on family planning which includes discussions of contraceptive methods, spacing of pregnancies, absence of children, adoption and artificial insemination.

As a whole, the text is well written, covers a wide variety of important topics, and clearly presents its material in an interesting, informal, non-technical manner.

**The Adopted Family.** By FLORENCE RONDELL and RUTH MICHAELS. 80 pages. Cloth. Crown Publishers. New York. 1951. Price \$2.50.

*The Adopted Family* is a well-meaning, naïve presentation in two parts: a guide for adopted parents, and material for reading to the child. External problems are optimistically described; the psychological implications, however, are nearly completely omitted.



**Errors of Psychotherapy.** By SEBASTIAN DE GRAZIA. 236 pages. Cloth. Doubleday. New York. 1952. Price \$3.00.

During the last few years one has noted a gradual breaking away of many practitioners from psychoanalytic theories of causation and methods of treatment of mental illness. One might call it a swing away from amoral theories to moral theories. Perhaps it is hard to say just who started this swing but many will probably give credit to Harry Stack Sullivan. At any rate, this change is well worth consideration since it seems, to many, a more understandable, a less involved and, perhaps, a more human approach to the understanding of mental illness, particularly of the neuroses. Everyone who has studied mental illnesses and has tried to treat them has recognized many errors, but the human mind is a complex mechanism, and one tends to hesitate to condemn aggressively any of the theories set forth in the last 50 years. One may hope that the present swing is the one that will give the answers, and yet may wonder if therapy will be easier to accomplish.

Dr. de Grazia has written a very interesting book which should be read by all persons whose professions deal with emotional illnesses. His *Errors of Psychotherapy* refers to an approach to the understanding of mental illness rather than to a method of therapy. He criticizes the lack of unity among the secular schools of psychotherapy and the failure to recognize the moral factors causing mental illness. The author holds that neurosis is a moral disorder. "The persons who come to the psychotherapist are all fired in the same crucible. They have thought bad things or done bad deeds, and so they suffer, ground and baked in a hot oven, cooked, no less, in their own galled conscience."

Dr. de Grazia believes that each person has grown up emotionally under the guidance of an authority (mostly parental) and that—because of this—the neurotic, when seeking help, seeks a substitute authority, the therapist, who, through his methods of listening to the patient's problems, can, if he is not careful, make serious error and, thereby, lessen his authority and fail in therapy. The author reminds the reader that, as one listens, such expressions as "uh, uh-huh, m-hm, uhn-uhn" may greatly influence or disturb the confidence of the patient in the therapist. "With the sounds decoded, the moral judgment appears. . . ." The patient gets an idea of how the therapist reacts, approves or disapproves, agrees or disagrees, is shocked or not shocked. ". . . moral authority, an idea widely spurned by modern healers of the soul, is the crux of psychotherapy. The crystals that remain after distilling the multiplicity of therapies are not many. A bewildering array of brilliants dwindles down to a precious few: Neurosis is a moral disorder, the psychotherapeutic relationship is one of authority, the therapist gives moral direction."



The author calls attention to another "error" of modern psychotherapies. He states that the patient's moral problems (what are right or wrong for the patient) are minimized by the therapist; that what, to the patient, is wrong is not to be ignored since what he is seeking is not a method of ignoring his problem but a method of obtaining forgiveness. "Take each school of psychotherapy separately; it is a redemptive system, designed to relieve guilt. Take them together; they are a snarled mass of conflicting moral teachings. Take them separately, tune them together like the strings of a lute, harmonize their knowledge and ideals; they become religion."

Taken as a whole, this book is a very provocative one and, although many will severely criticize it, it should receive respectful consideration.

**The Heart of a Man.** By GEORGES SIMENON. Translated from the French by Louise Varèse. 213 pages. Cloth. Prentice-Hall. New York. 1951. Price \$3.00.

*The Heart of a Man* tells about the life and—in detail—the loves of a famous actor, after his doctor has informed him that he has a heart disease and only a short time left to live. The morbid atmosphere of the chief character's experiences may be depressing and plain "scary" for some readers. It may be relaxing because it provides escape for others, as the reader will be completely absorbed by the novel. Whichever the experience, the reader will admit it's a book that's hard to put down, morbid and mysterious to the finish.

It will be up to a later generation of psychologists and critics to find out why so many of our professionals find mystery novels appealing and relaxing. Simenon's novels, this reviewer feels, certainly will make good specimens of the successful mystery novels of the 1950's.

**Conflict and Light.** Studies in Psychological Disturbance and Readjustment. Père Bruno de Jesus-Marie, O. C. D., editor. Translated by Pamela Carswell and Cecily Hastings. 192 pages. Cloth. Sheed & Ward. New York. 1952. Price \$2.75.

This book is a collection of papers published originally in French under the editorship of Père Bruno de Jesus-Marie, O. C. D., director of *Études Carmelitaines* of Paris. They were written by psychiatrists, other doctors and priests, all of whom express belief in a moral theory of behavior and of mental illness. They describe the various types of sin, the misinterpretations of sinfulness, the sense of guilt, the false sense of guilt acquired by children, the interpretations of morality, the psychological aspects of conscience as seen in mental illness, and the psychological benefits of confession. Some parts of the book become involved in theological language but, generally, one might say that the ideas expressed will be considered sound theoretically.



**The Mystery of Hamlet King of Denmark or What We Will.** By

PERCY MACKAYE. xiii and 676 pages. Cloth. Bond Wheelwright. New York. 1950. Price \$6.50.

These four plays form a prologue to Shakespeare's *Hamlet* and strive to give the reader the events leading up to that play. Much use is made of mysticism—events in *Hamlet* being foreshadowed in these plays. The first act of *Hamlet* is used as the last act of this tetralogy. It is of course unfair to use the original as a comparison, but the subject invites it. In this sense, the chief thing that Percy Mackaye lacks is a feeling for the dramatic—he is unable in just a few words to make a situation apparent. The poetry cannot be called an imitation of Shakespeare; it is rather the poetry of another man written somewhat in the style of Shakespeare. As poetry, however, it can stand on its own feet, rising to brilliance only occasionally, but at the same time seldom descending into mediocrity.

Those looking for an explanation of the inner drives of Hamlet will not find it here. While in plays as allegorical as these almost any interpretation could be made (as indeed they can be in Shakespeare himself) there is no strong backing for any of the analytical theories concerning Hamlet—such as an extremely strong Oedipus complex. It should be stated that this book is one of the finest pieces of typography this reviewer has encountered recently, something especially remarkable in a book this large at the price at which it is sold. It would be almost worth while to obtain the book as an example of the art of bookmaking alone, though there is more than that to recommend it.

**The Correspondence Between Paul Claudel and Andre Gide.** 299

pages. Cloth. Pantheon. New York. 1952. Price \$4.00.

When the correspondence of a literary figure is published, the usual fault to be found is the lack of background material and the fact that the correspondence has little to offer to the general reader, as it does not have sufficient literary or historical value to make a book of interest to those not close students of the man or his times. These faults are not to be found in this collection. Every effort has been made, by including selections from the *Journals*, etc., to provide the reader with clues as to the thoughts and actions of the writers at the time of writing the letters.

Gide was a man who was continually searching for—searching for and never finding—a set of guideposts. These letters deal with long, sporadic, and unsuccessful efforts of Paul Claudel to convert him to Catholicism; and they show the evolving of Gide's thoughts through the years. They end at the time when Claudel reluctantly concedes to himself that his efforts have been unsuccessful—that Gide lived by a set of religious ideas and sexual mores that were antagonistic to his own.



**The Untouchables.** By ALFRED MAUND. 32 pages. Paper. Southern Conference Educational Fund, Inc. New Orleans. Price (in quantities) 50 cents a pamphlet.

This is an ably and indignantly written pamphlet, written by a native Southerner and illustrated by the drawings of Ben Shahn, on the subject of racial segregation and discrimination against the Negro in American hospitals. The statistics quoted and most of the material cited are from Southern or border states and the District of Columbia, although one New York City and one Chicago incident are mentioned. Its publishers announce its purpose is to combat segregation. It is worth the attention of any person concerned with hospital problems, particularly with those of general hospitals; but just how much application it has to the North, or even how accurately it reflects the situation in the South, is difficult to judge. It also shares a common fault of publications of this kind; places where there is no discrimination whatever—like the hospitals of the New York State Department of Mental Hygiene—are unmentioned; and a careless reader is likely to conclude that the practices complained of prevail generally.

**Prescription for Marriage.** By MARY BRINKER POST. 233 pages. Cloth. Messner. New York. 1952. Price \$3.00.

This text is a psychological novel dealing with what the author feels is the most significant and rewarding relationship in life—marriage. "Companionship, tenderness, understanding, and especially passionate, mutually satisfactory sexual love create so important a relationship that a woman should hold on to it stubbornly, no matter how deeply shaken she may be by disillusionment." The author writes this conviction into her story of Laurie and Martin Joyce. Laurie felt the impact of the world at 19 when she believed that she should emulate other wives and drive her husband to the top of his profession. But she found there was no prescription for marriage when the storms came in the form of mounting bills, and mounting quarrels, slander and jealousy. Her "togetherness" with Martin was a dying dream; how it was resurrected is this book's story.

**Children Deprived of a Normal Home Life.** 38 pages. Paper. United Nations, Department of Social Affairs. New York. 1952. Price 25 cents.

This pamphlet covers the problem of children without a normal home life—in very brief paragraphs, devoted to each aspect of the situation. The information given and the recommendations put forward are too much in outline form to be useful in themselves, but the references given and the broad coverage make the pamphlet valuable to those connected with the field involved.



**Victory Over Fear.** By JAMES BENDER. 236 pages. Cloth. Coward-McCann. New York. 1952. Price \$2.95.

Dr. Bender, director of the National Institute for Human Relations in New York, is the author of several "How to . . ." books and of several speech correction books. He writes clearly and pleasantly. He uses non-technical language and his references to, and quotations of, many well-known persons make the reading more interesting.

His theme throughout the book emphasizes a common-sense approach toward the understanding of fear. He quotes William James as follows: "Common sense is not sense common to everyone; but sense in common things." As he describes and defines fears Dr. Bender calls attention to periodic mood swings and recommends that each person make his own mood swing calender so that he will know the best time to approach difficult problems, and so that he will recognize his low swings and not become panicky about them. Dr. Bender suggests, too, what can be called Coe's method of talking one's self out of fears and creating confidence in one's self. "Thus many of our fears are really apprehensions of what restitution or expiation will involve. We are torn between the realization that we ought to right a wrong we have done and the reluctance to pay the price. So long as we bear this conflict within us, we are a house divided against itself, and our self-respect suffers."

Fear of old age is a subject which the author discusses very nicely. He gives the oldster hope, courage and a plan of living. He recommends that older persons develop wider interests, make many new friends, marry again, take reasonable and sensible care of physical health, adjust finances to stretch dollars, seek part-time work, not give up education, and develop a sense of humor.

Other excellent chapters of the book refer to the fear of poverty, the fear of poor health, fear of expressions of love, fear of death and fear created in children by inconsistent parents.

**Defense of Freedom.** By the Editors of *La Prensa*. 315 pages. Cloth. John Day. New York. 1951. Price \$4.00.

When a government fights a newspaper, the government, sooner or later, is going to win. This book is the chronicle of the struggle of *La Prensa*, one of Argentina's great liberal newspapers, to continue publication—a losing struggle, but no less memorable because of that. This book shows with great clarity the uses of mob psychology; and perhaps, may serve as a warning that such things do happen in previously free countries. The book is absorbing in those sections where it deals with the actual conflict with the Peron government, but tends to be somewhat flowery and pedantic in spots.



**The Donkey Shoe.** By G. B. STERN. 254 pages. Cloth. Macmillan. New York. 1952. Price \$3.50.

The famous-actress lonely-daughter theme has been played ad nauseum by authors good and bad. Therefore, it is to G. B. Stern's everlasting credit that she can sweep the same strings with a difference.

Too often, modern novels degenerate into the bogs of sentimentalism when frustrated child and adolescent parent form a psychiatric case study. This time, both mother and daughter grow a little, and that little creditably, so that the reader can relax and identify with the child who always understood her artistic parent but couldn't show it, and with the mother whose first love belonged only to the theater. Thus we may criticize, but we cannot condemn Jessica's failure of her child in her early years; and can wince, even while we understand, her callous reference to her daughter before all admirers as "the little donkey." The donkey symbolism cuts a deep pattern in the unconscious of both mother and daughter . . . a pattern which every page of this brilliant novel reveals while one grows up with its characters, watching donkey and race horse run the course together.

**The Steps of the Quarry.** By ROBERT TERRELL. 350 pages. Cloth. Crown Publishers. New York. 1951. Price \$3.00.

This is a remarkable book in these days of prevalent trash in literature. A series of realistically depicted characters, centering around a captured concentration camp in Austria at the end of the war in Europe in 1945, is used by the author to delve into the psychologic make-up of a few conflict-ridden soldiers and their girls.

There is a peculiar dichotomy between conscious and unconscious tributaries in this author. On the conscious level, a series of objections are justified. The book is aphoristically written, its politics are dubious or naïve, and sometimes a peculiar antipathy toward the United States is discernible. On the other hand, unconsciously, the author is capable of evoking the feeling of true compassion for some of his *dramatis personae*—and that is more than can be said of most of the unpsychological contemporary novels.

**The Accuracy of Teacher's Judgments Concerning the Sociometric Status of Sixth-Grade Pupils.** By NORMAN E. GRONLUND. 62 pages. Paper. Beacon House. New York. 1951. Price \$2.75.

It is found by the author that while there is a difference between the abilities of different teachers to estimate the sociometric status of their pupils, the only external factor that effected a change in this ability was a course in child development. While the material contained in this pamphlet is interesting, it is doubtful if any but specialists will find it sufficiently valuable to justify purchase—particularly at the price for which it is sold.



**Psychoanalysis as Science.** By E. R. HILGARD, L. S. KUBIE, and E. PUMPIAN-MINDLIN. 158 pages. Cloth. Stanford University Press. Stanford, Calif. 1952. Price \$4.25.

A compilation of three lectures, delivered at the California Institute of Technology, this book is highly unsatisfactory, and will please neither friends nor foes of analysis.

The psychologist on the team simplifies the ABC of analysis, tries to adduce inconclusive experiments, and bases his approach on "I do not care whether we end up believing that Freud was a scientist or a romanticist."

The analyst, though presenting the case for analysis, brings in so much of his own predilections and antipathies that his piece becomes more a personal credo than a general statement. And the biologist of the trio is rather condescending: "Whether one wishes to accord psychoanalysis the rank of a science or not depends upon one's personal point of view. Psychoanalysis must content itself at its present stage of development with establishing what appear to be significant, but not exclusive, correlations rather than specific causal relations."

The book can be summarized by stating that better arguments pro and con have been adduced by other investigators.

**Annual Review of Psychology.** Vol. III, 1952. Colvin P. Stone and W. Taylor, editors. 462 pages. Cloth. Annual Reviews, Inc. California. 1952. Price \$6.00.

This is the third volume of this review. It presents a greater breadth of selection of papers from outside the United States; and, apparently, the hope is to increase this trend. The present collection covers a wide range of special fields, with excellent papers by several well-known, outstanding scientists. Despite its limitations in trying to cover a tremendously wide range of interests, it provides a superficial idea of new developments during the past year. However, it is questionable whether the best in this type of endeavor has been reached, or whether a similar review for each field might not be more appropriate in providing more comprehensive data for each area. Until the latter is possible, however, the present method serves a significant purpose.

**Morning for Mr. Prothero.** By JANE OLIVER. 242 pages. Cloth. David McKay. New York. 1951. Price \$2.75.

Equipped with modern gadgets, charts, a "psychotherapeutic department," "emotional recording apparatus for troubles in the whole world," with people "recorded in dominant colors, etc.," this is a novel about the "beyond." All this is seen through the eyes of an elderly British surgeon. The book seems intended to describe a conversion; but, despite his good intentions, the author's production will appear to many as only an inept blasphemy.



**The Mount Sinai Hospital of New York.** By JOSEPH HIRSH and BEKA DOHERTY. 285 pages. Cloth. Random House. New York. 1952. Price \$5.00.

The history of the 100 years during which the Mount Sinai Hospital has been in existence will be enjoyed by all persons who have been associated in any way with it. Data for the book have been taken from the hospital archives, the meetings of the boards of trustees, the medical board, the annual reports, and from the hospital journal.

In a very pleasant style, the authors have recorded the many changes and events which have taken place. They have included many pictures of the hospital and of the men and women associated with it during the last century.

The appendices record the chronology, the names of past and present officers, trustees, superintendents, committee members, the present medical and surgical staff members and other important information about the events which have taken place at that institution.

**Essays in Applied Psychoanalysis.** Volume II. By ERNEST JONES, M. D. 383 pages. Cloth. Hogarth. London. 1951. Price 21/.

These essays use a psychoanalytic approach to the fields of folklore, anthropology, and religion—relating unconscious drives and associations to conscious beliefs and superstitions. A very broad base of knowledge is involved—the tracking down of a subject may lead from the Egyptian *Book of the Dead* to Welsh legends and back again, taking in Sanskrit word roots on the way. For thoroughness, the essay on “The Symbolic Significance of Salt” is remarkable. A study of the role of salt in fertility rites and other ceremonies and superstitions relates it, in the unconscious, to semen and urine. Several of Jones’ articles deal with religion, some with present-day beliefs; and interpretation here may be considered highly controversial by many.

This book forms an important addition to the literature of non-clinical psychoanalysis. The style, though dealing with a complex subject, is of great clarity.

**Paralysis Agitans.** Acta Psychiatrica et Neurologica; Supplementum 54. By HENRY MJÖNES. 195 pages. Paper. Ejnar Munksgaard. Copenhagen. 1949. No price stated.

The author has studied the genetical aspects of paralysis agitans and concluded that there is a Mendelian mechanism. Inhibitions of manifestation are concluded to be the causes of the difference between the theoretical 50 per cent hereditary occurrence and the 30 per cent occurrence found. Supportive data are presented.



**Psychoanalytic Theories of Personality.** By GERALD S. BLUM. XVIII and 219 pages. Cloth. McGraw-Hill. New York. 1953. Price \$3.75.

In *Psychoanalytic Theories of Personality*, Gerald S. Blum, the creator of the Blacky Picture Story Test, has attempted to present in an organized framework, the many diverse "psychoanalytic" theories of personality development and has purposed to evaluate these concepts from a scientific research point of view. The tenets of the leading theorists in the field, including those of the orthodox Freudians, the early dissenters, and the neo-Freudians, have been systemized by the author according to the chronological sequence of personality development, beginning with birth and eventually reaching adult character structure. The orthodox psychoanalytic theory receives the most coverage since, as Blum states, "It is the most carefully worked out." Although the author holds that many of Freud's original formulations are outmoded, he, nevertheless, severely criticizes the neo-Freudians, i. e., Horney, Fromm, Sullivan and Thompson, chiefly, it appears, for remaining in the fold, and paraphrasing many of the orthodox views with little reference or acknowledgment.

At the conclusion of each chapter, the existing evidence and research relevant to the divergent positions are evaluated by the writer in an effort to find the most applicable and worthy for future research explorations. These critical notes, as stated by the author, "are oriented primarily toward the research possibilities inherent in the content" and consist of "brief resumes of existing experimental data, suggestive evidence from related fields like cultural anthropology and learning theory, consideration of logical inconsistencies and semantic confusions, and comparisons of overlapping views."

What Blum actually succeeds in presenting is only a superficial, cursory and incomplete account of the salient psychoanalytic views. He should, nevertheless, be lauded for his endeavor to organize, by age levels, the many divergent and seemingly irreconcilable psychoanalytical theories and, more important, he deserves encouragement for his attempt to verify these concepts by existing research data in an effort to initiate the development of a sound and integrated theory of personality.

**Mary Lincoln: Biography of a Marriage.** By RUTH PAINTER RANDALL. xiv and 555 pages. Cloth. Little, Brown. Boston. 1953. Price \$5.75.

By going to original sources, the author has pieced together the threads of Mary Lincoln's life and come forward with a picture that differs in many respects from the generally accepted one. Far from being the nagging shrew who made Lincoln's life and marriage miserable, she is shown here as the partner in an essentially happy marriage. The author believes her never to have been psychotic, or even close to it, but concedes that at times she was extremely neurotic in her actions.



**I, William Sutton.** By QUENTIN REYNOLDS. 273 pages. Cloth. Farrar, Straus & Young. New York. 1953. Price \$3.50.

All who read this book will be intrigued by Willie Sutton's life and, at the same time, will feel very sympathetic toward him. As the expression goes, "He is a character!" He is a person whom no one can understand. He admits that he does not understand himself. The reader gathers that, in spite of all his illegal behavior, Sutton is sincere, and is morally good and honest in his illogical way. He is, in many ways, like the pyromaniac who cannot evade the temptation of setting fires. Sutton cannot evade the temptation of robbing a bank. This, and escaping from prisons, seem to have been his only "vices." It is regrettable that this intelligent, kindly and capable man has selected a career which places him behind bars for the rest of his life (unless he breaks out again, and his records show that this is a possibility).

Sutton has permitted Quentin Reynolds to record his autobiography on the condition that the money received from the sale of this book be "... put ... into a trust fund of some kind to help kids during their difficult years, that might convince people that I was on the level." Sutton says that he wishes nothing for himself.

**Speech Rehabilitation in Cerebral Palsy.** By MARION T. CASS. 212 pages. Cloth. Columbia University Press. New York. 1951. Price \$3.00.

Of the more than 1,000,000 speech-handicapped school children in the United States, the cerebral palsied have received the least consideration—due to public ignorance—yet there are 150,000 of them, and three-fourths of these are estimated to be educable.

Dr. Marion Cass, an outstanding authority, teacher and lecturer in this field, defines cerebral palsy as "a disturbance of the muscle function which has its origin in the brain."

Once people thought the cerebral palsied to be feeble-minded because limbs jerk and do not co-ordinate. Now such fallacies have been exposed; but there is a tremendous job of public education still to be done. In fact, New York and California are the only two of our 48 states that have actually granted money to alleviate the education inadequacies for this group.

Cerebral palsied children are emotionally unstable ... a condition rooted in frustration caused by the disease itself (impairment of the inhibitory mechanism of the brain) plus parental overprotection and the public's general attitude of rejection. The earlier cerebral palsied children begin their training the better the results. Three-year-olds attend special classes in California.



Each case of cerebral palsy is an individual one. The *spastic* must be taught muscle relaxation. He is not so affectionate as the *athetoid* type, because physical petting actually hurts his muscles. The *athetoid* lacks control of the speech muscles. He must be taught control of joint motion. The *ataxic* child, on the other hand, has a sense of movement, but a poor sense of position, so that he cannot execute precise speech movements.

The type of program necessary to educate these children adequately as proposed by Dr. Cass, will involve the establishment of special classes where trained personnel will carry on medical and physical rehabilitation, correlation between the home and the school, and the establishment of classes for vocational training and guidance.

If schools like this can be established successfully in other states as they have been in New York and California, and if the public can be educated to see the value of this work, we shall have taken a step forward in reclaiming citizens . . . a project certainly as vital as the reclaiming of soil.

Parents, teachers and speech therapists will find numerous helpful exercises and suggestions for treatment in Dr. Cass' book.

**Unquiet Minds.** Leaves from a Psychologist's Casebook. By Dr. EUSTACE CHESSEY. 232 pages. Cloth. Roy. New York. Price \$3.50.

Dr. Eustace Chessy, British psychologist, well known for his previous book, *Love Without Fear*, recounts in this present volume some of the true case histories in his files. His approach is simple narrative and is interesting.

The rationales behind Dr. Chessy's approach to these cases are revealed in the introduction by the following statements: "We can no longer delude ourselves into believing that we really possess freedom of choice and action. . . . The general argument put forward by those with moderate views is that personality—and therefore behavior—is determined by our physical and emotional endowment which in turn are molded by the forces of environment and heredity. There is no exact time when the influence of one stops and that of the other takes over." In summarizing this nature-nurture influence the author says, "The argument, in the end, is less whether we are free or not but how far within the limits set for us we can be free and responsible."

The author chose eight cases from his files, each of which centered around a special theme, such as divorce, juvenile crime, prostitution, and suicide. He tells these stories from a factual, sympathetic position, neither explaining nor condemning but always illuminating them with his own strong belief in a Divine Being. He does not, in any instance, deal with means and methods of treatment or therapy. In a postscript he gives a follow-up on the case histories and a plea for a society which does not foster human misery.



**Lesbia Brandon.** By ALGERNON CHARLES SWINBURNE. With a commentary by Randolph Hughes. xxxv and 580 pages. Cloth. British Book Centre. New York. 1952. Price \$7.50.

The most extraordinary thing about this book, by far, is the commentary. To anyone accustomed to the staid and reserved habits of literary critics Mr. Hughes' antics will prove a shock. This reviewer was amused and delighted to encounter here a man who is not in the least disturbed at calling previous "students" of Swinburne "incompetents," and "fools," and by reporting "the uncomfortable feeling that one is in the presence of cretinism." Mr. Hughes has done his own work, wherever it is at all possible, from the original sources, and exhibits a thorough knowledge of the subject. This reviewer is not in the position to set himself up as a judge of the accuracy of the conclusions drawn—but a reply from one or more of the maligned Swinburne scholars, none of whom Mr. Hughes has the slightest use for, should set the stage for a literary battle-royal.

As far as the treatment goes of the psychopathology, only too evident in the novel, this reviewer has few complaints. In his handling of a dream experienced by the hero of this novel—who is admittedly in many respects a personification of Swinburne himself—why does Mr. Hughes think it "improbable" that it could have been a dream Swinburne experienced, especially since it is—as it has been ably interpreted by Mr. Hughes—a classic example of unconscious sexual conflict? The novel itself shows Swinburne's preoccupation with flagellation as a means of expressing masochistic desires—which in Swinburne's case went beyond unconscious levels, and with the "incest motif," which probably did not rise above the unconscious level. The novel, which is incomplete and is published now for the first time, certainly should have been published—and before this—but there will be few who will place it on as exalted a level as does Mr. Hughes. Both from the point of view of the psychopathology evidenced, and from the literary standpoint it is worth reading, as is the commentary—though many readers may wish, with the reviewer, that at times Mr. Hughes would relax a bit. A little vitriol goes a long way, and there is far more than a little here. After all, not everyone believes that misrepresentation of an author calls for eternal damnation!

**The Soviet Impact on Society.** By DAGOBERT D. RUNES. xiii and 202 pages. Cloth. Philosophical Library. New York. 1953. Price \$3.75.

To deny the very real menace of Communism to our free society would be an absurdity. On the other hand, the use of "labels" and "catch phrases" in the attack upon Communism is a habit to be deplored. Dr. Runes, instead of writing a study, has written a polemic, and in so doing has made this book of slight value to serious students of the subject.



**Jung's Psychology and Its Social Meaning.** By IRA PROGGOFF, Ph.D. xviii and 299 pages. Cloth. Julian Press. New York. 1953. Price \$5.00.

The main purpose of *Jung's Psychology and Its Social Meaning*, says the author, is to "facilitate the process of integrating Jung's concepts into the mainstream of contemporary thought." To accomplish this aim, Progoff attempts a comprehensive and systematic presentation of Jung's complicated and often inconsistent tenets in terms of an interpretation which the writer believes will make it possible for them to be critically evaluated and worked with in the related fields of psychology and social study.

Although this book deals mostly with the essential concepts that Jung uses to analyze the processes underlying psychic phenomena, the author does endeavor to present and elaborate upon the hypotheses which Jung generated, but did not develop, and their general influence in stimulating scholarly investigations in the fields of social science. Indeed, the importance that Progoff attributes to Jung's contribution to the understanding of culture and historical change is demonstrated by the writer's somewhat extreme conclusion, in which he states, "that Jung's concepts have a ground-breaking power for the social sciences, but that they will make their impact fully felt only when they have been reformulated and redefined with reference to the specific problem of social study. When this has been done, Jung's radical and profound penetration is bound to have a tremendous effect on the social study of man."

**The Trouble with Cinderella.** By ARTIE SHAW. 394 pages. Cloth. Farrar, Straus & Young. New York. 1952. Price \$3.75.

Instead of viewing the kingdoms of the world and discarding them, Artie Shaw struggled and fought for them from the poverty of the East Side slums, up to the peaks of popularity as a top-flight American band leader. He made his first million several times over. In fact, it was just at that point, that Shaw stopped the music and sat down to think. He discovered that he had got on the merry-go-round of money and fame "out of my own inner weakness and Cinderella wishes."

Not until after he had left the Hollywood scene and had played a part in the World War II drama, did Shaw seek help through psychoanalysis where he admits, "a guy can learn a hell of a lot about himself, that he can learn in no other way."

This book is written thoughtfully, intelligently and with deep integrity. Shaw's style is as striking as his music. Like Thurber's sketches, his easily flowing lines reveal some very important truths about you and me and the ideals of mass taste. For those of us who suspect that the American dream of "sucece\$\$" may be a nightmare in disguise, here are some substantiating facts.



**Current Therapy, 1953.** Latest Approved Methods of Treatment for the Practicing Physician. Howard F. Conn, M. D., editor. 800 pages. Cloth. Saunders. Philadelphia. 1953. Price \$11.00.

As the title of this book indicates, it does not pertain to diagnosis; but, after a diagnosis is made, *Current Therapy* gives the doctor all he needs to know about the treatment of any disease. *Current Therapy* is far better than any ordinary textbook on therapy because it is up to date. The methods of treatment are discussed clearly, briefly and specifically. In many cases, methods are given by two or more contributors so that the reader has more than one doctor's opinion.

*Current Therapy* has over 370 contributors, most of whom are well known. In its 800 pages, it describes treatment of nearly all medical diseases. There are also a section which gives additional data on drugs mentioned, a table of metric and apothecaries' systems, and a table for making percentage solutions. The indices locate items, authors and contents accurately.

**Child Psychiatric Techniques.** By LAURETTA BENDER, M. D. 360 pages with index. Cloth. Thomas. Springfield, Ill. 1952. Price \$8.50.

This is a valuable, comprehensive formulation of the care, treatment and observation of problem children gleaned from years of experience at the children's ward at the Psychiatric Division of Bellevue Hospital, by Bender, Schilder and others. A multitude of techniques are described, such as puppetry, clay modeling, figure drawings, visual-motor productions, and other expressive media.

The inclusion of a wealth of case studies, many followed longitudinally, gives the book greater meaning and value. Through utilization of the same cases in each chapter, the reader gains a valuable horizontal study by seeing the individual's reactions to the various techniques. The many illustrations further enhance the instructive potential of the volume. The material actually represents the contributions of several fields including psychiatry, psychology, education and art, and the book constitutes a useful reference volume.

**Enardo and Rosael.** By ALEJANDRO TAPIA Y RIVERA. xix and 56 pages. Cloth. Philosophical Library. New York. 1952. Price \$2.75.

This little allegory deals with an angel who grew wearied with the placid life in Heaven and came to Earth in pursuit of the man she had come to love, Enardo. While in itself a minor piece of writing, *Enardo and Rosael* may serve to stimulate enough interest to have other works of this Puerto Rican philosopher translated.



**Goya's Caprichos.** By JOSÉ LÓPEZ-REY. 2 volumes, xv and 224 pages, and xiv and 265 pages. Cloth. Boxed. Princeton University Press. Princeton. 1953. Price \$12.50.

The series of plates that Goya published under the title of "Caprichos" offers one of the most devastating satires—in dream-fantasy form—on the falseness and immorality of an age that has ever been produced. The author has used Goya's own explanations as the basis for his interpretations of the symbolization in the plates. While recognizing the dream origins of the series, the possibility that the plates might well represent an expression of fantasy life in Goya on a pathological level is not even mentioned—nor is there any attempt to explain Goya's preoccupation with certain forms of imagery, such as aerial flight and anal exhibitionism. Despite the fact that this book makes no excursions into the dynamics of the subject, those interested will find it invaluable—the inclusion of preparatory drawings among the plates, which comprise the second volume, and the commentaries on the plates contribute much to understanding.

**No Postponement.** U. S. Moral Leadership and the Problem of Racial Minorities. By JOHN LA FARGE, S. J. 239 pages. Cloth. Longmans, Green. New York. 1950. Price \$3.00.

In this book, Father La Farge sets forth his opinions relative to racial and minority problems. He informs the reader on what specific efforts the Catholic Church has made in an effort to alleviate the problems. He describes the history of the Catholic Interracial Council and what this organization has accomplished.

He expresses opinions which are shared by many, namely, that the government and the people of the United States preach tolerance but fail to abide by their preaching; that they are inconsistent in what they say and do; that other peoples of the world question the sincerity of their preachings.

Father La Farge proposes that the idea of white racial superiority and inconsistent dealings with underprivileged peoples everywhere should be repudiated; that United States citizens should familiarize themselves with these problems and demand appropriate legislation that "it is time for all of us to drop once and for all the notion that any simple, facile formula will serve to eradicate prejudice and implement the great principles of human justice and brotherhood; altho, as I have said, these principles in themselves are simple and clear. . . . The time for the human race to lift up its hope is now, not in the near or remote future. Each of us can begin to work for these ends in our own religious association in our own community for God's most holy sake."



**New Play Experiences for Children.** By RUTH E. HARTLEY, LAWRENCE K. FRANK, and ROBERT M. GOLDENSON. 66 pages. Paper. Columbia University Press. New York. 1952. Price 75 cents.

**Growing Through Play.** By RUTH E. HARTLEY. 62 pages. Paper. Columbia University Press. New York. 1952. Price 75 cents.

These two pamphlets are based on a project by the Caroline Zachry Institute for "an exploratory study of play in fostering healthy personality development by young children." This study itself was published in a volume entitled *Understanding Children's Play*. Such additional material as was felt to be of special interest and value to educators and guidance workers is presented in the two pamphlets reported in this review. *New Play Experience for Children* contains the observations of groups of nursery school children in exploratory projects with puppets and miniature life toys and in planned play groups. *Growing Through Play, Experiences of Teddy and Bud* presents running accounts of "Teddy's" and "Bud's" individual and group play experiences over a period of many months.

The two pamphlets are well documented by concrete material from the play sessions. The approach is more from a guidance level than a psychoanalytic. As a result, the interpretations of the data tend to be superficial and lack integration. However, the material should prove useful for presenting various techniques of play therapy and should be of benefit for teachers and guidance workers.

**Monkey on My Back.** By WENZELL BROWN. 270 pages. Cloth. Greenberg. New York. 1953. Price \$3.50.

Mr. Brown's book brings the reader closer to the problem of narcotics addiction. In it he makes use of actual cases to show what factors led to addiction. The author not only stresses the importance of hospital care but also the need of psychiatric aid to help resolve the inner problems. He points out economic and environmental causes and also points to family relationships—all problems requiring aid, often psychiatric, before the addict can effect a permanent cure. Written primarily for the layman, and often dramatized, this book still remains a valuable work.

**The Tender Age.** By RUSSELL THACHER. 277 pages. Cloth. Macmillan. New York. 1952. Price \$3.00.

Here is a well-written, though strange, book, depicting maturation-pains of a boy of 17. The family setting is unusual—a father who admits to, and continues, an extramarital affair. The author evokes sympathy for his hero; he is, however, incapable of explaining any of his reactions. Pity alone is inadequate; somewhere, somehow, between the lines, the real writer makes the unconscious of the reader understand what is really going on. Nothing of this is included in the rather pessimistic and atypical novel.



**The Refugee Intellectual.** By DONALD PETERSON KENT. xx and 317 pages.

Cloth. Columbia University Press. New York. 1953. Price \$5.00.

The immigrants to this country from Germany and Austria between the years 1933 and 1941 comprised a unique group in that they represented for the most part people who had made satisfactory economic adjustments in their own lands and were leaving them for political reasons. This book is a statistical survey of their degree of integration into the American culture and the effects, both financial and social, of the change. Sociology is a field where statistical studies have been, to a large part, lacking, and, as this book shows, the inclusion of statistics does not necessarily impair readability.

**Dante's Drama of the Mind.** By FRANCIS FERGUSON. x and 232 pages.

Cloth. Princeton University Press. Princeton. 1953. Price \$4.00.

This is an interpretation of the *Purgatorio*, showing it to be the transitional section of the *Divine Comedy*. The author stresses the differentiation to be made between Dante the *author*, and Dante the *voyager*—with the *Purgatorio* representing Dante the voyager slowly rising above worldly thinking to a conception of spiritual values. The role of Virgil is taken to be that of the worldly enlightened, leading Dante on—but by the end of the *Purgatorio* Virgil has completed his mission and can go no further. The author acknowledges indebtedness to the works of Jacques Maritain and T. S. Eliot; and, throughout, this is primarily a study in religious concepts.

**Selected Papers on Psychoanalysis.** By KARL ABRAHAM, M. D. 527

pages. Cloth. Basic Books, New York. 1953. Price \$6.00.

Psychoanalysis as a science is not a static thing—it, like the other sciences, has made great strides since its conception. For this reason, it is remarkable, not that some of the views of Karl Abraham have been superseded by later research, but that so many of his papers are applicable today. The emphasis in these papers is upon the purely clinical phases of the field. Any one interested in the history of the psychoanalytic movement will find this book invaluable; and, for that matter, provided the reader has a good background in the newer researches, there is much useful material from any standpoint.

**Twins.** By DOROTHY BURLINGHAM. 89 pages with 30 charts. Cloth.

International Universities Press. New York. 1953. Price \$7.50.

A study of three pairs of identical twins, this book is, from the theoretical standpoint, a rehash of the analytic ABC's, *anno* 1925. The pre-Oedipal phase of development is not included, or such "unimportant" topics as psychic masochism, and pseudoaggression. From a descriptive angle, the text is better; a series of detailed recordings from birth is included. Of interest, is the observation of the division in each pair of twins into one active and one passive partner.



**Psychology and Alchemy.** By C. G. JUNG. Volume 12 of the Collected Works. xxiii and 563 pages. Cloth. Pantheon. New York. 1953. Price \$5.00.

One does not have to be an adherent of the psychological theories of Jung to derive value from this book. Apart from the psychological interpretations, there is a wealth of source material for the student. Non-Jungians will find the third section, dealing with "Religious Ideas in Alchemy" to be most valuable. Readers of this publication will not need to be told that Jung devoted an enormous amount of research to the study of comparative religion, and he has covered his subject with commendable thoroughness. There are 270 illustrations, all of good quality, in the book.

**Satan's Children.** By GEORGES SIMENON. 298 pages. Cloth. Prentice-Hall. New York. 1953. Price \$3.95.

This book contains two short novels, and shows the French writer from his worst and best sides. The first story, *I Take This Woman*, is a mis-carried attempt at depicting a schizoid woman. The second, *Four Days in a Lifetime*, is a brilliant description of a masochistic weakling whose "business" is extortion. Of course, despite fine psychological insight, all the typical weaknesses, characterizing Simenon's literary work, are amply represented: his impatience, lack of working out, preference for violence, etc. Nonetheless, the understanding of his masochistic characters is so penetrating that one gladly overlooks these minor nuisances.

**Recollections of Andre Gide.** By ROGER MARTIN DU GARD. 134 pages. Cloth. Viking. New York. 1953. Price \$2.75.

The high claims made for this book as an aid to the understanding of the character of Gide are not borne out by the contents. The author makes the point that Gide "succumbed to the temptation of exonerating himself by some subtle chain of argument." In this case, while not exonerating Gide for any of his traits, such as masochism, homosexuality, or self-centeredness, there is reluctance throughout the book to relate incidents or cast light on subjects that have not already been dealt with by Gide himself. The resulting study is valuable as a supplement to already existing material, but does not shed light on many facets of Gide's personality.

**World Enough and Time.** By ROBERT PENN WARREN. 465 pages. Cloth. Random House. New York. 1950. Price \$3.50.

This book is concerned with perverted ideals of truth and justice. The characters, while perhaps suitable for case studies, are not credible in the setting. Their motivations are strange and unrealistic. As usual, the author shows craftsmanship in his writing, but he has loaded the book with so much extraneous detail as to impair the reader's train of thought.



**Adrenal Cortex—Transactions of the Third Conference.** Elaine P. Ralli, editor. 204 pages with 58 figures and 23 tables. Josiah Macy, Jr. Foundation. New York. 1952. Price \$3.25.

This book, chiefly referable to the subject of adrenal cortical steroids, thrashes out the chaff in the experimental and clinical observations on the interrelations between hypothalamus, ACTH, adrenal cortical steroids and renal function. Although there are five major subjects for discussion by R. F. Pitts; G. W. Harris; D. H. Nelson; O. M. Hechter and R. G. Sprague, it is not long before the 24 participants, whose extensive experience in the subject cannot be doubted, start the ball rolling in the direction of clarification.

As a result of the informal discussions and free expressions which differentiate assumption from observations, the reader can get an up-to-date review of what can be and what cannot be accepted. Therein lies the value of the text—from biogenesis to the application of the steroids in clinical practice. It is recommended to anyone who is thinking about, or is using, these hormones.

**The Therapeutic Community.** By MAXWELL JONES, M. D., and associates. xxi and 186 pages. Cloth. Basic Books. New York. 1953. Price \$3.50.

The preferred treatment for the neuroses has been psychoanalysis, but this long expensive process is limited as to the numbers it can handle. The project here described is an attempt to utilize techniques of group therapy in the treatment of psychoneurotics, with the emphasis on sufficient personality adjustment to enable the patient to make an economic adjustment successfully. The author shows himself to have an excellent orientation in analytic concepts, and applies them, on a limited scale, in therapy. Statistical evaluation of the results is lacking, but it is the opinion of the author, and also of the reviewer, that the project has shown promise and should be continued.

**Personality Measurement.** By LEONARD W. FERGUSON. xiii and 457 pages. Cloth. McGraw-Hill. New York. 1952. Price \$6.00.

The weakest portion of this book is that dealing with projective testing. Only two of these tests, the Rorschach and the TAT, are dealt with, and the treatment is rather unsympathetic. Little cognizance is taken of the unique value of the projective techniques when dealing with personality disorders, and the author, in apparently rating the TAT over the Rorschach, does not take into account the limited range of usefulness of the TAT. The treatment of the many tests described is statistical, and the handling of the non-projective tests is fairly comprehensive.



**The Bracelet.** By BEATRICE PAGE. 248 pages. Cloth. Bobbs-Merrill. Indianapolis. 1953. Price \$3.00.

This novel is the story of Jane and the antique gold bracelet given her in place of a wedding ring. It came to symbolize love that was not present in her childhood or marriage; and, in her relationship with her son by this marriage, symbolized only pain. Driven by guilt feelings concerning her father and former lover, she tries, in her old age, to atone by a reconciliation with her son. The technique of flashbacks is employed to reveal her former life. This reviewer feels that the book was drawn out unnecessarily, and that some of the force of the excellent writing was lost.

**Ernest Hemingway.** By PHILLIP YOUNG. viii and 244 pages. Paper. Rinehart. New York. 1952. Price \$2.00.

More of a study of the motivations and techniques of Hemingway than a critical appraisal of his works, this book explores the Hemingway "hero" and relates him to Hemingway himself—showing the high degree of identification. Far from being the generally accepted hard-boiled he-man, this hero is shown to be a man who is hurt and afraid, taking reckless chances not through lack of fear but because of great fear. The tendency toward suicide is always there, as is the unconscious desire for death. Thinking is not a luxury that is permitted a Hemingway hero—there is too much danger that the effects will be disastrous. The author exhibits a knowledge of psychiatry, though one might question his clarity of thought regarding it.

**Brothers and Sisters.** By EDITH G. NEISSER. 241 pages with index. Harper. New York. 1951. Price \$3.00.

This is a miscarried attempt at describing and explaining sibling rivalry. The reason for the failure is concentrated simplification, leading to concentrated naïveté. With minor exceptions, the author waters down or simply bypasses everything dynamic psychiatry has discovered. Wisdom's last words seem to be that a "certain amount of resentment, rivalry and jealousy is bound to occur"; the remedy seems to be found on the common-sense level. It is too bad that an unconscious part of the personality does exist. It complicates unnecessarily the life of authors and publishers.

**Sexual Harmony in Marriage.** By OLIVER M. BUTTERFIELD, Ph.D. 96 pages. Cloth. Emerson Books. New York. 1953. Price \$1.50.

Those in the psychiatric field must guard against being hypercritical of sex education books designed for laymen. This reviewer feels that this book could be of value to many about to be married. It gives much of the essential information about sex, and stresses the desirability of a satisfactory sexual adjustment. The terms employed are those the average adult can understand. The style will be too flowery for many tastes.



**Modern Headache Therapy.** By ARNOLD P. FRIEDMAN, M. D. 164 pages. Cloth. Mosby. St. Louis. 1951. Price \$4.00.

This book presents experiences in diagnosing and treating over 5,000 cases in three headache clinics of New York City. It presents the subject from the standpoint of the presenting and most prominent complaint. In one chapter, it shows to what extent certain investigations must be made for diagnosis. It is valuable for its references to underlying causes. The 15-page index would be worth more if some of the subjects referred to had more than a passing mention in the text. Results of therapy are not discussed, probably because of the need to treat the underlying conditions. For students, the book might be recommended.

**Fright in the Forest.** By BENN SOWERBY. 272 pages. Boards. Knopf. New York. 1951. Price \$3.00.

The external action in this novel is at all times secondary to emotional reactions. A man's search for himself at times carries the reader along, but at other times the reader must flounder as best he can. As might be expected in a book of this type, there are psychological overtones, but not of sufficient import to warrant its reading on that basis alone. The general level is rather above average, and, as this is a first novel, it is not unreasonable to hope that the next effort will be one that can be recommended without qualifications.

**Art and Technics.** By LEWIS MUMFORD. 162 pages. Cloth. Columbia University Press. New York. 1952. Price \$2.50.

The main theme of this book is the depersonalization of the individual, which is being brought about by the stress laid in our society upon the techniques of living, without sufficient emphasis being placed upon the person's need for self-expression. The author shows a good comprehension of modern psychological concepts. His attitude toward Freudian thinking, while not actively hostile, is that it too often tends to contribute to this depersonalization. The treatment of art forms is interesting in itself, but the major stress is placed upon art's place in society.

**By the Same Door.** By BLANCHE CHENERY PERRIN. 271 pages. Cloth. Macmillan. New York. 1951. Price \$3.00.

Here is a naïve novel about a bossy woman, finally "reformed" by her adolescent son. That things do not happen that way, is another story. The author overdoes Wilde's witticism, "Lying, the telling of beautiful untrue things, is the proper aim of art." Unfortunately, these "beautiful untrue things" must correspond to unconscious facts; otherwise the writer is not a creative writer but a typewriter operator. Not the slightest attempt is made (in the text, or between the lines) to explain the heroine's aggression in this novel; only the most banal conscious motivations are adduced.



**Women, Society and Sex.** Prof. Johnson E. Fairchild, editor. 255 pages. Cloth. Sheridan House. New York. 1952. Price \$4.00.

Anthropologists, psychiatrists, psychologists, a fashion editor, a college president and representatives from other fields and specialties here contribute the latest word on women in relation to today's social problems.

These writers first presented their ideas on the lecture platform of Cooper Union in the 1951-1952 Adult Forum. There was unusual interest in the lectures; and, in the case of several, disappointed crowds were turned away. The general reader can now enjoy the treatment of this appealing subject by the 13 lecturers who offer opinions which are thought-provoking, frequently conflicting, and without conclusions, but nevertheless stimulating.

**Nobody's Child.** By PHYLLIS HAMBLETON. 283 pages. Cloth. Rinehart. New York. 1951. Price \$3.00.

This is a naïve novel, dramatizing the unhappiness of a child of divorced parents. Horror after horror is piled up to demonstrate the commonplace: Happy homes are better than broken up homes. Nobody denies that divorce can increase the psychic burden of children; at the same time, it is conveniently overlooked that a bad marriage of the parents is just as unfavorable. The author exemplifies with a girl of 11—if harm was done to this child by divorce, it was done much earlier. Finally, the author places an exaggerated emphasis on reality, once more overlooking the fact that reality is only the raw material which can be eclectically and unconsciously used or misused. The book gives the uncomfortable impression that it is merely an exploitation of a popular topic; the technique is on the same level.

**The Dividing Stream.** By FRANCIS KING. 312 pages. Cloth. Morrow. New York. 1951. Price \$3.00.

Mr. King's book is a rather boring and overextended novel about a few American and British tourists in Italy. It contains, however, a good textbook description of a masochistic couple; the drawback is that no inner motivations are provided. Mr. King must have studied the newer psychiatric literature; he understood the mechanics, not the dynamics. He ends with the desperate question: "Why do we cling so to the people who make our lives miserable, cling to our crosses instead of climbing off them?"

Taking the prevalent low level of contemporary literature into account, it is already an achievement when the proper questions are asked. Intuitive writers provide—without knowing it themselves—answers between the lines. This is not the case in this novel.



## CONTRIBUTORS TO THIS ISSUE

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M. RALPH KAUFMAN, M. D., C. M. Dr. Kaufman is director of the department of psychiatry of Mount Sinai Hospital, New York City, and he is clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University. Born in Bessarabia in 1900, he was graduated from McGill University Medical School in 1925, had a medical internship at Manhattan (N. Y.) State Hospital and later was with the Vanderbilt Clinic, Montefiore Hospital and Boston Psychopathic Hospital. He held a Commonwealth Fund research fellowship for three years, during which time he spent 16 months at the University of Vienna.

Dr. Kaufman has been clinical director of McLean Hospital, Waverley, Mass., and has been in private practice in Boston and New York City. He served in the United States army medical corps during World War II and rose in rank from major to colonel. He was neuropsychiatric consultant for Pacific Ocean Areas. He received the Bronze Star in 1944 and the Bronze Star with first oak leaf cluster in 1951.

Dr. Kaufman has been president of the American Psychoanalytic Association and the Boston Psychoanalytic Society and is the author of numerous psychoanalytic and psychiatric publications. He is at present neuropsychiatric consultant to the Surgeon General, Department of the Army; is president of the Mental Health Film Board of the National Association for Mental Hygiene and is a member of the New York State Mental Hygiene Council. He is a diplomate of the American Board of Psychiatry and Neurology. He is a fellow of the American Medical Association, the American Psychiatric Association and the New York Academy of Medicine, and is a member of various other professional societies.

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NEWTON BIGELOW, M. D. Newton Bigelow, M. D., is commissioner of mental hygiene of New York State and is editor of this *QUARTERLY*, from which latter position he is on leave of absence during his tenure of office as commissioner. Dr. Bigelow, born in London, Ontario, in 1904, is a graduate of the medical school of the University of Western Ontario. After a general internship, he joined the New York State hospital system, with which he has been connected ever since. He became senior director of Marcy (N. Y.) State Hospital in 1945 and held that position when he was named commissioner of mental hygiene by Governor Dewey in 1950. He is a diplomate in both neurology and psychiatry of the American Board of Psychiatry and Neurology and he is the author or co-author of a number of articles on psychiatric subjects.



**HYMAN S. BARAHAL, M. D.** Dr. Barahal is assistant director of Pilgrim (N. Y.) State Hospital. A graduate in medicine of Wayne University in 1931, Dr. Barahal interned at the Gorgas Hospital, Panama Canal Zone, and has since devoted his major interests to psychiatry and psychoanalysis. He was trained in psychoanalysis at the New York Medical College. Dr. Barahal was a major in the army medical corps during World War II, was chief of psychiatry and sociology at the U. S. Disciplinary Barracks at Greenhaven, N. Y., and chief of the neuropsychiatric section at Mason General Hospital, Brentwood, N. Y. He is a diplomate of the American Board of Psychiatry and Neurology and is the author of numerous papers on psychiatric and psychoanalytic subjects.

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**DEREK H. MILLER, M. B., Ch. B.** Dr. Miller, born in Hull, England, in 1923, received his medical and surgical degrees from the University of Leeds, England, in 1947. He interned in 1947 and 1948 at the United Leeds Hospitals, and was junior lecturer in physiology at the University of Leeds in 1948.

Dr. Miller served as a captain in the Royal Army Medical Corps from 1949 to 1951. He was a physician at Saskatchewan Hospital, Weyburn, Saskatchewan, during 1951 and 1952. Since July 1952, Dr. Miller has been a resident in psychiatry at Topeka (Kas.) State Hospital. He has published previous scientific articles on the subject of physiology; and he is author of a statistical assessment of results of treatment with penicillin of cases of venereal disease in the British Army.

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**JOHN CLANCY, M. B., B. Ch.** Dr. Clancy is a graduate of the National University of Ireland in 1946, L. M. Dublin 1947. He interned at St. Vincent's Hospital, Dublin, and Coombs Lying-in Hospital, Dublin. Dr. Clancy was a physician at Saskatchewan Hospital, Weyburn, Saskatchewan, during 1951.

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**E. CUMMING, M. A.** Mrs. Cumming was a social biologist attached to the psychiatric department of the Saskatchewan government at the time of her co-authorship with Drs. Derek H. Miller and John Clancy of the paper published in this issue of *THE PSYCHIATRIC QUARTERLY*. She is at present doing postgraduate work at Harvard University.

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**ROBERT R. SCHOPBACH, M. D.** Dr. Schopbach, born in 1919, was graduated from Jefferson Medical College of Philadelphia in 1944 and certified by the American Board of Psychiatry and Neurology in 1950. After directing neuropsychiatric consultation service in the army he served



a three-year residency in psychiatry and neurology under the Veterans Administration Philadelphia Dean's Committee. He is now chief of the neuropsychiatric department of The Clifton Springs Sanitarium and Clinic, Clifton Springs, N. Y. He is a member of the Finger Lakes Psychiatric Society and the American Psychiatric Association. Other publications by Dr. Schopbach have appeared in *Growth*, *The Journal of the American Medical Association*, *Philadelphia Medicine*, and the *Archives of Neurology and Psychiatry*.

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**J. LAWRENCE ANGEL, Ph.D.** Dr. Angel is associate professor of anatomy and physical anthropology at the Daniel Baugh Institute of Anatomy of the Jefferson Medical College, Philadelphia. He was born in London of Anglo-American parents and was trained at Harvard, from which he received his doctorate in anthropology in 1942. He has been engaged in research on the anthropology of chronic diseases with National Institutes of Health support. These research subjects have included constitutional study of hospital patients (hypertensives, hyperthyroids, arthritics, and the varicose, as well as the obese). He has undertaken a social biological history of the Greek people, ancient to modern, as revealed in examination of almost a thousand skulls and skeletons (made possible by Guggenheim and Wenner-Gren Fellowships).

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**MORTON WACHSPRESS, M. D.** Dr. Wachspress is a member of the psychiatric staff of the 141st General Hospital, APO 1005. He is now 28 years of age. He received his pre-medical training at C. C. N. Y., and the University of Michigan; and his M. D. from Western Reserve University School of Medicine in June 1949. He interned at Maimonides Hospital, New York City, until July 1950. He had a psychiatric residency at the Northport VA Hospital until December 1950.

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**ALBERT BERENBERG, M. A.** Albert Berenberg, at present clinical psychologist at the Osaka Army Hospital, Osaka, Japan, is 32 years old. He received his B. A. in psychology from New York University in 1946; his M. A. in 1948; and completed his doctorate training in clinical psychology there in 1950. He has, since his recall to active duty been assigned as clinical psychologist to the 382d General Hospital; the 141st General Hospital, and the Osaka Army Hospital, all located in the communications zone of the Far East.

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**AVROHM JACOBSON, M. D.** Dr. Jacobson was chief of the neuropsychiatric service of the 141st General Hospital when the data was compiled for the paper, of which he is co-author, in this issue of *THE QUAR-*



TERLY. He took his B. A. at the University of Michigan in 1944; his M. D. at Tulane in 1944; he is 32 years old. He interned at Newark (N. J.) Beth Israel Hospital; and took a residency in psychiatry at Middletown (N. Y.) State Hospital. He then went on active duty with the army medical corps, attending the army school of neuropsychiatry in 1946; thereafter serving as psychiatrist at Mason General Hospital, West Brentwood, N. Y., and later at the Pentagon Dispensary. Upon discharge, he took a fellowship in psychiatry at St. Elizabeths Hospital in Washington, D. C. He attended the Washington School of Psychiatry and had training with the Washington-Baltimore Institute of Psychoanalysis in 1948-50.

Dr. Jacobson is certified in psychiatry by the American Board of Psychiatry and Neurology. He has been an instructor in clinical psychiatry at the Georgetown University of Medicine; he is a member of the American Psychiatric Association, the Washington (D. C.) Psychiatric Society, the American Medical Association and other professional societies. Following recall to active army duty in 1951, he was assigned as chief of neuropsychiatric service at the 382d General Hospital, the Nara Convalescent Center, Osaka Army Hospital, and 141st General Hospital, all in the Far East Command. He is now living in Asbury Park, N. J. He is author or co-author of a number of psychiatric contributions.

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NATHAN S. KLINE, M. D. Dr. Kline is director of the new long-term interdisciplinary research project recently set up at Rockland (N. Y.) State Hospital. A native of Philadelphia, a graduate of Swarthmore College and Clark University, and a graduate in medicine of New York University, Dr. Kline was director of research at Worcester (Mass.) State Hospital when he was named to head the new Rockland project. Dr. Kline interned at Saint Elizabeths Hospital, Washington, D. C., held a psychiatric residency there and later did postgraduate work at Harvard, Princeton and Rutgers. He was assistant to Drs. J. Lawrence Poole and Fred A. Mettler in the co-operative brain surgery research project conducted by Columbia University and New Jersey State Hospital at Greystone Park. He is 36 years old.

The new research project which Dr. Kline now heads calls for the co-operation of at least eight medical and social science disciplines. It involves work in research psychiatry, psychology, endocrinology, biochemistry and nursing. Dr. Kline himself has been appointed to the department of neurology, College of Physicians and Surgeons, Columbia University.



## NEWS AND COMMENT

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### GLUECK TO GIVE FIFTH HUTCHINGS MEMORIAL LECTURE

Dr. Bernard C. Glueck, Jr., director of the Sex Offender Research Project of the New York State Department of Mental Hygiene, and supervising psychiatrist at Sing Sing Prison, Ossining, N. Y., will deliver the fifth annual Hutchings Memorial Lecture on October 5, 1953 in the auditorium of the College of Medicine at Syracuse University. The title of his lecture is "Psychodynamic Patterns in the Sex Offender." The lecture is one of a series in honor of the late Dr. Richard H. Hutchings, former superintendent of Utica and St. Lawrence (N. Y.) state hospitals, and editor of this QUARTERLY. He died in October 1947.

Dr. Glueck is in private practice at Ossining and is an associate psychoanalyst at the Columbia University Psychoanalytic Clinic. He is a diplomate of the National Board of Medical Examiners and a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is a fellow of the American Psychiatric Association and a member of other professional organizations. The son of Dr. Bernard Glueck of New York City, Dr. Glueck, Jr., is a graduate of Harvard in the class of 1938.

The Hutchings Memorial Lectures are co-sponsored by the Dr. Richard H. Hutchings Memorial Trust Fund Committee, the Onondaga County Medical Society, the Syracuse Academy of Medicine and the College of Medicine, Syracuse University. Dr. Hutchings taught at Syracuse for many years, where he was professor of clinical psychiatry at the College of Medicine.

Last year's memorial lecturer was M. Ralph Kaufman, M. D., chief psychiatrist at Mt. Sinai Hospital, New York City. Previous lecturers were Robert A. Cleghorn, M. D., associate professor of psychiatry at McGill University, who delivered the 1951 memorial lecture; Harry C. Solomon, M. D., medical director of Boston Psychopathic Hospital, who lectured in 1950 and Winfred Overholser, M. D., superintendent of St. Elizabeths Hospital, Washington, D. C., who initiated the series with the 1949 lecture. Members of the medical profession and students of medicine are invited to the lectures. Dr. Glueck's lecture, like the four which preceded it, will be printed in a forthcoming issue of THE PSYCHIATRIC QUARTERLY.

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### STATE HOSPITAL ALUMNI ELECT

Clarence P. Oberndorf, M. D., was elected president, Richard L. Frank, M. D., vice-president, and Samuel R. Lehrman, M. D., secretary-treasurer, at the annual meeting of the New York State Hospital Medical Alumni Association.



## GÉZA RÓHEIM, PH.D., PSYCHOANALYST, DIES AT 61

Géza Róheim, Ph. D., of New York City, internationally known psychoanalyst and anthropologist, died on June 7, 1953 in Mt. Sinai Hospital, New York City, after a week's illness. He was 61 years old. Born in Budapest, Dr. Róheim became a psychoanalyst through the personal influence and interest of Freud. The possessor of an international reputation before he came to the United States, he had made his home in America since 1938.

Dr. Róheim was on the staff of the Hungarian National Museum from 1917 to 1921. He was a practising psychoanalyst in Budapest in 1927 and 1928. From 1929 to 1932 he was engaged in field work in anthropology, sponsored by Marie Bonaparte, in Somaliland, Central Australia, Normanby Island and among the Yuma Indians. He was a training analyst and lecturer in psychoanalysis at the Budapest Psychoanalytic Institute from 1932 to 1938 and a guest lecturer at the Berlin and London psychoanalytic institutes. He was a teaching assistant at Worcester (Mass.) State Hospital in 1938 and 1939, a lecturer at the Rand School, New York City, in 1940. He was a guest lecturer at the New York Psychoanalytic Institute and an honorary member of the New York Psychoanalytic Society. He did field work among the Navaho Indians in 1947. He published approximately 250 papers in English, German, Hungarian, French and Spanish. His books include *Australian Totemism; Animism, Magic and the Divine King; Primitive High Gods; The Riddle of the Sphinx; The Origin and Function of Culture; War, Crime and the Covenant; The Eternal Ones of the Dream; and The Gates of the Dream*, published just after his death. He was managing editor of the annual *Psychoanalysis and the Social Sciences*.

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## WILLIAM B. NOYES, M. D., MENTAL SPECIALIST, DIES AT 87

Dr. William B. Noyes, one of the oldest active practitioners in the field of mental and nervous disorders, died at his home in New York City on June 20, 1953 at the age of 87. Dr. Noyes, born in New Jersey, a graduate of Amherst and of the College of Physicians, Columbia University, studied at Berlin and Vienna before engaging in his years of practice in New York. His field of particular interest was mental deficiency in childhood.

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## ENGEL IS PRESIDENT OF PSYCHOSOMATIC SOCIETY

George L. Engel, M. D., was elected president; Lawrence S. Kubie, M. D., president-elect, and Theodore Lidz, M. D., secretary-treasurer at the annual business meeting of the American Psychosomatic Society on April 18, 1953. Elected to the council of the society were Robert A. Cleghorn, M. D., Jacob E. Finesinger, M. D., and Jurgen Ruesch, M. D.



## MENTAL HEALTH ASSOCIATION FINANCES RESEARCH

A program for direct allocation of grants for research on mental illness, in a large-scale financing program, has been announced by the National Association for Mental Health. The plan, just adopted by the board of directors, is announced by Robert M. Heininger, executive director of the association. It represents a new departure in the policy of the organization, which, except for sponsorship of research on schizophrenia, for which the 33rd Degree Scottish Rite Masons also contributed, has confined its efforts largely to encouraging research and offering consultative services.

The new association policy, it was announced, will mean that funds will have to be raised by the association on a much larger scale than ever before. Preliminary planning on the research program is to get under way this coming fall. The new plans were adopted on the recommendation of Thomas A. C. Rennie, M. D., chairman of the association's professional committee and professor of psychiatry at Cornell University Medical College. As a part of the general project, a commission for research on mental illness will be named from leading figures in psychiatry, associated fields, and government circles. The commission will study the research projects now being carried on, recommend the spots where new research is most urgently needed, and recommend allocations of funds.

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## JUVENILE COURT STANDARDS REVISED

A revision of juvenile court standards to emphasize the protective nature of juvenile court proceedings, the necessity of avoiding rigidity in handling the social and emotional problems of children, and the placing of more emphasis on the legal rights of children and their parents, is being prepared by the Children's Bureau, United States Department of Health, Education and Welfare and the National Probation and Parole Association. The announcement by Dr. Martha M. Eliot, chief of the Children's Bureau, says that in preparing the revised standards a group of some 30 experts, including juvenile court judges, probation officers, directors of voluntary and public child welfare agencies, and lawyers, recently spent a three-day conference in Washington, going over a draft of revised standards.

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## WALTER GOLDFARB, M. D., PSYCHIATRIST, DIES AT 43

Dr. Walter Goldfarb, New York City psychiatrist, died in New York City of a heart attack on June 4, 1953. A graduate of Yale Medical School, Dr. Goldfarb served in World War II as a lieutenant-colonel in the army medical corps. He was the author of numerous psychiatric articles, among them contributions to this *QUARTERLY*.



**ROBERT V. SELIGER, M. D., ALCOHOLISM AUTHORITY, DIES**

Robert V. Seliger, M. D., psychiatrist and nationally known authority on alcoholism, died in Baltimore, April 24, 1953, following a cerebral hemorrhage. He was 52 years old. Dr. Seliger, born in New York City, was graduated from Fordham and the University of Maryland, from which he received his medical degree. Long associated with the Johns Hopkins Hospital and the Johns Hopkins University Medical School, he was director of the National Committee on Alcohol Hygiene, Inc., and was the author of *Alcoholics Are Sick People*, and other works on alcoholism and psychiatry. He was president of the Medical Correctional Association, an affiliate of the American Prison Association; was a fellow of the American Psychiatric Association, and a member of other professional organizations. He leaves his widow, a son and a married daughter. Among his numerous writings, he had been a contributor to this journal.

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**NEURO-PSYCHIATRIC CENTER COMPLETES THIRD YEAR**

More than 9,000 psychiatric treatments, besides psychological tests, social service interviews, diagnostic consultations and neurological examinations have been carried out during the first three years of the New York Neuro-Psychiatric Center, the officers of the institution have announced. The Center, established in 1950 by William D. Sherwood, M. D., professor and chairman of the department of neurology and psychiatry at Columbia Post-Graduate Medical School and Hospital, and associates, now has a staff of 20 psychiatrists in addition to members of other disciplines. The Center is said to be the only psychiatric clinic supported entirely by patients' fees, which start at \$6.50 and are based on ability to pay.

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**TEN MILLION PAMPHLETS DISTRIBUTED**

The ten-million mark in the distribution of mental health educational leaflets and pamphlets has been passed by the National Association for Mental Health, it has been announced by Robert M. Heininger, executive director. The association, organized three years ago, reports an increasing demand for this material and notes that the greater part of it is being used by newspaper and magazine writers, teachers, clergymen, nurses, doctors, social workers and industrial mental health personnel.



## PSYCHIC DETERMINISM AND RESPONSIBILITY\*

BY LAWSON G. LOWREY, M. D.

As a clinical psychiatrist whose first scientific training was in anatomy and pathology, I was both surprised and pleased at an invitation to speak before the Guild of Catholic Psychiatrists on "psychic determinism," a formulation belonging in conceptual fields quite different from those which ordinarily concern me. Another reason I have for being pleased is that I was forced to make some very wide excursions into philosophy and metaphysics, theology and morals, which I might not otherwise have found the opportunity to do. I think, at least I hope, that I gained considerable insight into the polemics and semantics involved in what superficially appear to be some irreconcilable differences. There seems to be opposition not only in opinion, but in concepts as well.

Early training and psychiatric experience conditioned me to try always to ascertain the scientific and clinical facts, as we know such facts, with regard to any controversial proposition or one new to me. Inevitably I find myself cutting through the logomachy which so often obscures the real issues. Quite naturally, a delineating process was functioning as I delved into the involved question of psychic determinism. The result is that I find it impossible to discuss determinism as one of the ways of solving universal problems. I can discuss the concept only from a clinical viewpoint, with special reference to what light psychiatry can throw on the idea and, on the other hand, with reference to what help the concept may offer to psychiatric understanding.

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The questions involved in any exhaustive consideration of psychic determinism are closely interwoven with many other issues. There are the questions concerning the essential nature of man, the relationship between mind and body, concepts of the soul and the animating principle, the objective and the subjective aspects of experience, and so on through a long list of opinions and explorations about which men have argued since they first discovered they could "think abstractly." This discovery seems not to have been an unmixed blessing. Reading what philosophers, theologians, and scientists have had to say about some of the key ideas, one is im-

\*Presented in abbreviated form before the Guild of Catholic Psychiatrists, Atlantic City, May 12, 1952. Summary published by the Guild, 1953.



pressed by the ability of many to split the semantic hair into an infinite number of threads. Apparent disagreement often seems to come down to a difference in words only, and not a difference in the essence of the concept. The ultimate synthesis may scarcely seem to justify the rather extraordinary circumlocutions which precede it.

One of the first steps in considering this problem was to ascertain what determinism as a concept means to people of diverse viewpoints who have either used it or denied its validity. The best short definition I found of its meaning in philosophy is given by Webster. He defines determinism as: "The doctrine that all acts of the will result from causes that determine them. Determinism characteristically denies the reality of alternative modes of action but may maintain that the will is free in the sense of being uncompelled." Another meaning he gives is: "The doctrine that things as they are are the result of necessity; any theory which regards a certain set of factors or order of phenomena as primary or determining causes of cultural change or social evolution; as, economic determinism."

With regard to the meaning of determinism in and for philosophy, the first sentence seems to follow the general law of cause-effect. Since it is not worded to specify that *every* particular act of the will results from, and *only from*, one cause which invariably produces the particular act, it may be wondered if the present pluralistic approach to questions of etiology in medicine may be applicable, at least in some degree, to an elucidation of psychic determinism. However, since the next sentence quoted from Webster states that determinism denies the reality of alternative modes of action, we seem to be in something of a dilemma in logic. Or is this dilemma just a matter of semantics? (Note the round-about fashion in which determinism "may maintain" the idea of a free will.)

As scientists, we have been trained to associate cause and effect. We have also learned something about sequences of cause and effect, in that a cause for a particular effect may in its turn be an effect of some other cause. It is a personal impression that in present medical thinking we are more concerned with sequences and sequential relationships than we are about precise delimitation of a cause and *an* effect. This is related to our increasing awareness of the many variations, existing not singly but in mul-



tuples, which must be taken into account in explaining the reactions of the human body and the behavior of the individual. Particularly in psychiatry, one-to-one correlations are found practically not to exist with special reference to many cause-effect couplets. Instead, if we attempt to correlate at all, we must deal with multiple variables. Actually, we always find that the simplest act has a complex set of causes. Not only that, but one simple act, a result, will be made up of many interrelated phenomena. And, finally, even our simplest acts cause some sort of effects or results.

The scientific approach is quite different from the philosophical. Science is analytical and descriptive. It starts with careful observations of any sort of phenomena, described objectively and accurately, and proceeds from the general to the particulate. Science uses hypotheses as tools in its search for data which verify knowledge—factual material that can be tested by others who use the same or different techniques. By varying its techniques, science can deal not only with concrete materials, with things and objects, but also with intangibles, imponderables, and the apparently unmeasurable.

Philosophy, on the other hand, deals chiefly with synthesis and interpretation. It proceeds from the particular to the general, largely on the basis of hypotheses. Philosophy requires the data of science, and utilizes them to erect more and more comprehensive hypotheses about problems of the universe concerning which no conclusive data are available. In a sense, therefore, the philosophical approach is speculative and reaches its most interesting peak when ingenious reasoning utilizes known facts to support some huge, over-all synthetic interpretation.

It thus appears that the essential task of science is to seek out facts; to subject ideas, hypotheses, or abstractions to the test of reality; not a metaphysical or conceptual or dialectic reality, but the kind of reality which can be perceived, apperceived, intellectually manipulated, and communicated to others. Here we see clearly the limitations of science and scientific methods, since there remain questions for which science has no techniques of approach, and certainly no answers. Among these questions, some of which theologians and philosophers debate with great vigor, are issues which cannot be brought into sensory representation by any method so far conceived. Notwithstanding what has just been said, there are



matters concerning which we can and do know we are right through the test of repeated experience.

With this short general statement in mind, one may return to the discussion of determinism. In the definition cited, "acts of the will result from causes that determine them," and "alternative modes of action" are denied. This has evidently been interpreted pretty universally as meaning that, deterministically, man has no freedom of action, no volition of his own, but can act only in accordance with specific causes, presumably arising within himself. In psychiatry, if such a doctrine were construed to mean that all behavior resulted from specific intrapsychic cause-effect constellations, there would then seem to be no rationality in man. On abstract grounds, and reasoning from hypothesis to hypothesis according to the rules of logic, it should not be too difficult to arrive at conclusions indicating that man is not a rational being, that he lacks spontaneity, is a robot, and is the hapless victim of his own unfathomable drives. He would then not be responsible for any of his acts, even those that are generally approved. As a matter of fact, most of us have talked just that way, though not in the same language, about some *other* person or persons at one time or another.

It proved difficult to elucidate the place of determinism in psychic functioning. The obstacle is precisely what seems so to delight the abstract thinkers. That is, the philosophers' urge to establish a universal law leads them to erect an elaborate series of hypotheses to a point where the final structure is so tenuous that it can fall simply for lack of support. I am plainly incapable of discussing this, and probably any other philosophical concept, from the universal point of view. Speaking only for myself, most systems of philosophy seem to have their origin in an antagonism to some set of ideas, or perhaps to the promulgator of the ideas. It often seems that more effort is spent in disproving the disliked system than in proving the proposed one, and much of the controversy is distinguished by considerable heat. A tremendous amount of antithetical debate has revolved around religious concepts and creeds, the relationship of man to God, problems of life and death and corporeal and spiritual entities and continuities, so that factors of strength of belief and conviction and zeal, not to mention bigotry, have entered into the discussions.



Determinism as a theological concept seems to have reached its pessimistic peak—so far as any hope is concerned that individual man may have some independence of thought and action and any possibility of creative ability and spontaneity—in John Calvin's stern doctrine of predestination. This inflexible ecclesiastic preached that God foresaw everything and therefore irrevocably sealed the end of every man, whether he was to be saved or damned. Such a pessimistic theology, ground in on the young, who were taught that they were created in sin and born as sinners, certainly gives an ultimate bleakness to life! For, unless the individual finds the courage to become a skeptic with reference to such a doctrine, he must believe that no matter how sincerely he tries to make his peace with God, it will be of no avail in changing the ultimate fate of his soul. Conversely, no matter how great his sins, these too could have no effect on his fate. This is not an attempt to reduce this point of view to an absurdity; it is merely that the absurdity seems to exist in the concept and seems to outweigh any possible human values.

Many philosophical systems are absolutist, all-and-none in their finality and polarity; at the same time they are carried to such extremes that they cease to bear any clear relationship to the facts of life. Many of our philosophers seem not only to reside in ivory towers, but to live in towers on such high peaks that the earth of facts is only distantly glimpsed from time to time. It is here that untrammelled common sense, that rarest of all judgmental factors, can come to our rescue. For common sense makes us put these highly abstract ideas and elaborate systems to some sort of pragmatic test. Sooner or later, this same common sense leads us to relinquish the untrue and the unworkable, the wishful thinking, the superstitions and the preconceived prejudices, in favor of that which is at least nearer the true and the workable, and closer to facts that are testable. Common sense is a matter of "looking at the record"; at its best and in its most refined form, it is science and the scientific method. It requires open-mindedness and a willingness to learn.

Suppose, then, we turn our attention to the object of our professional interests and activities, the individual man. Man is a finite, mortal creature, of complex chemical structure, and he is also a marvelous chemical factory; he has form and structure and movement and function; a reality to himself and to all of us. He is en-



dowed with life operating at several levels—the tropic, the automatic (or vegetative), the reflex, the perceptive, and the adaptive (imagery-thought, selective behavior). Most important of all to us as psychiatrists, man is possessed of consciousness and all that enters into consciousness in the way of memory, ability to reason and form judgment, to learn and to act selectively; the power to feel, to inhibit and to suppress. We might argue till Doomsday about the origin of man and the ultimate causation of his behavior, whether he is mind or matter, or neither or both, and still be at odds about points materialist and idealist; mechanistic or casuistic. There are, however, certain matters of agreement, even though we may not be able to define them in precise and painstaking detail.

At the risk of seeming absurd, let us start on the areas of common agreement with this very elementary proposition: that man is first and foremost a living organism, and as such passes through a life cycle which has its own peculiar laws of growth and development, of evolution and devolution, of sentience, and of death. These laws are similar to, partake of, but are not identical with, those which apply to living organisms generally. In a world of living things characterized by extraordinary variabilities in organisms which possess enough common characteristics to be classed together (the birds or the trees, for example), man's variations in size, shape, color, and general physical structure are remarkably slight by comparison with what they might conceivably be. We are aware of certain evolutionary phases in the development of man, both during the embryological period and in the postnatal organismic behavior. We also see that for many functional capacities, or even for such static matters as size, man is strikingly inadequate when compared with some other animal forms. In hearing, seeing, smelling, strength, speed, endurance, and other specific qualities, man is markedly unequipped by contrast with various particular species.

What distinguishes man from all other living forms is the vast superiority and flexibility of his adaptive faculties. He can think and learn and remember; he can experiment and change his course as a result. He can act and he can learn to modify his actions. His mind—that outstanding functional capacity which differentiates man—gives significance to what he perceives and extracts further meanings by associating and correlating even the seemingly irrelevant. I am unable to find anything in our knowledge



of man or of biology or of the universe in general that says clearly and unmistakably that living organisms *inevitably* follow any precise mathematical or chemical or physical or even spiritual formulae. The first law of life, the living principle, seems to be the law of variation. In the case of the living organism, it is the coalescence of multiple variables into some sort of individuation that gives us the special entity. This is what differentiates the "you" and the "me" and the two billion other people who differ in many ways, from the simple to the complex, but are nevertheless recognizable human beings with a comparatively narrow over-all range of variation.

We clearly recognize the factor of individual differences in people both in structure and in functioning, despite certain common characteristics. We say, and correctly, that every trait or characteristic, every structure and every function, every rhythm and every quality of the human being which we are able in any way to measure or estimate, has its own "normal range of variation." We believe, by extension, that those characteristics and functions which we cannot quantitate must also have some sort of normal or usual range of variation.

We surely can agree—and for our present purposes it is not essential that we be able to explain all these points—that such attributes of the human mind as the emotions and the instinctive drives exist as variable potential capacities. They are part of the teleological endowment of human protoplasm, with its highly elaborated central nervous system. Surely we can be as certain of this as we demonstrably are that intelligence is a variable potential capacity, which can, after a fashion, be measured by utilizing certain tools of comparison. From clinical observations it appears that we also agree on the importance in human development of the experiences, the accidents and incidents, the rewards and punishments, the stimuli and the frustrations, the pressures and the tensions of living. We must include in our considerations the prenatal period of growth in a highly specialized environment, the tremendous event of birth, and then, especially, postnatal experience with all its internal life-process-maturations, its external pressures, and outward behavior and group adaptations. We know that all these things play their role in the development of every one of our potentials, even though we may not be able to assign to each its proper weight. We are always the same, but never the



same; new variables, even if only new combinations of old variables, complicate or alter a habit pattern or introduce a new reaction.

There was a time when the attention of clinicians and scientists alike was focused practically entirely on the conscious mind, and structuralization of mental functions was in terms of "faculty psychology." The divisions of mind thus set up are still useful in studying both normal and abnormal mental functioning. But in the past 50 years we have learned a great deal about the unconscious, a sector of mental functioning that had more or less been accepted as a concept before that time, though very little importance had generally been attached to it. Puzzled to account for many symptoms of disturbed mental function which did not correlate with any organic neurological involvement, the clinician formerly ascribed many of these to "disorders of the will" and tried methods of persuasion and suggestion in their treatment. Hypnosis was more highly regarded for its effect upon the patient's will than for the opportunity it gave to investigate the content of the unconscious in its relation to the symptoms of the patient.

I remember Morton Prince's demonstration of a case of multiple personality, which was later published in detail. It seemed to me then that the great interest was in the phenomenology displayed by the several personalities, with their apparently unlearned and unexperienced characteristics, and with the split in consciousness, more particularly the disordered will. I remember no attempt to correlate the content of the productions with early experience, to interpret the symbolisms, or even to recognize them. Nor do I recall that any special effort was made to analyze the rather marked emotional reactions of the patient. It seemed to me then, and even more strongly now, that the unconscious as a repository of dynamic forces, submerged memories and emotional conflicts simply was not recognized. It certainly was not probed and utilized in the interests of the patient. I say all this despite the fact that my own notions of the unconscious at that time were extremely nebulous, because, as short a time ago as 30 years, the will and its disorders occupied so much time and attention in psychiatric training.

The development of psychoanalytic facts and theories regarding the unconscious and its role in the production of mental disorders, as well as in everyday life, has revived the controversy about psychic determinism and its ultimate relationship to individual re-



sponsibility. I gather from reading and discussion that one argument runs like this. The unconscious is both a vaster area and is far more dynamic or forceful than is the conscious. As a result, our behavior, our emotions and even our thinking are largely dictated by forces entirely outside of conscious control. It should be recalled here that the unconscious contains not only the biological instinctive drives and impulses, the egocentripetal, asocial, amoral, hedonistic motivations, but also the repressed material related to painful, emotionally traumatic experience, plus the unassimilable emotions such as guilt, related to unsolvable (at least unsolved) conflicts between opposed inner drives. This is not, of course, a complete description of the unconscious, its content and its dynamics. For present purposes it is only necessary to point out that for the unconscious to operate effectively, it must have some relationship to consciousness. In some operations, it must work through consciousness; in others, we become acutely, and often painfully, aware of the results of unconsciously determined activities.

The id, the ego, and the super-ego are constellations of dynamisms represented in both the conscious and the unconscious. There is a barrier to free passage back and forth, else there would be chaos indeed, but the barrier is not impermeable. It appears that certain emotions have in fact a considerable facility in passing from the unconscious to the conscious where, being detached from the original nucleus and thus free-floating, they attach themselves to other nuclei and play havoc with what might otherwise be suitable, adequate reactions.

What I have said about the conscious and the unconscious seems to me merely to multiply the number of variables which must be brought into some sort of co-ordination before any kind of activity representing expression can ensue. One could increase the number of variables rather considerably if the automatic and reflex patterns that might conceivably be involved were also considered.

Probably the point can be made clear by concentrating on what happens in the selection of a course of action, the variables lying in both the conscious and the unconscious. I speak here of "selection of a course of action" quite deliberately, since I believe that this can and does occur. Even in the case of well-established habit patterns, whether simple or complex, there was a time in development when these had to be learned by patient repetition of,



not only the positive action, but repetition of the inhibition of the opposite action as well. Just as a movement of an arm in one direction demands contraction of one group of muscles and relaxation of the antagonists, so it seems to be with mental processes. One can see in the negativism of children, how a stimulus such as a request, an order, or an offer starts up contradictory impulses, and how the opposing impulses may come to expression through different parts of the motor system. Thus a child may say, "No I won't," as he actually begins to carry out the requested act.

Any stimulus, simple or complex, of necessity evokes a number of associations, for recognition, for understanding, for judging, and for expression. It is axiomatic in our profession that a repeated constellation of historical, physiological, psychological, and social circumstances which seem to be roughly parallel or comparable by our best standards of judgment, will certainly not always evoke an identical response, either in the same or in different individuals. Something was added or subtracted, perhaps a chance factor; something was learned, or emotional values varied. What simply must be true, at least to my way of thinking, is that the organism is in a state of constant flux, and so is the mind. Changes in reaction are, therefore, to be expected as a matter of choice, not of compulsion.

Philosophers may not accept this because they become absorbed in their own doubts and theories. They do not seem to follow the method of seeking facts with which to answer current questions, well knowing that each new set of answers has its own crop of further questions. This method is the crux of the scientific approach. As clinicians, we know that eventually we arrive at a point where we can find no further answers. In psychiatry, for example, our great question is: Why? What makes people behave as they do? Why does one child with an IQ of 150 do poorly in school, so poorly in fact that neither his teachers nor his parents can accept the fact of his intellectual superiority, while another child of the same age and IQ does even better than his superiority would indicate? Except conjecturally, based upon prior clinical experience, no one can possibly answer that question as it stands, but we do know where and how to look for the correct answers. Then, at some place along the line, we arrive at a point where we can no longer really know what the concatenation of circumstances and causative factors actually was. We can only make some inferences whose probable



validity will depend on the breadth and depth of our clinical experience and how well we have assimilated it. We could theorize about the difference in behavior of the two hypothetical children and erect a system of cause-effect relationships and sequences. The systematic answer could be completely true to life and yet not apply in more than small details to any particular child.

It seems to me that a philosopher could, if he wished, take the proposition as stated and proceed from hypothesis to hypothesis until he arrived at some complicated and abstruse set of conclusions, which he would present as his final judgment of the reasons for the difference. When one reads that a philosopher (Zeno) reduced reason to an absurdity, so that even its existence could be denied, it can be concluded that philosophers can prove or disprove anything. We all know that statistics do not lie, but that meretricious, or even honest, statisticians can certainly make statistics prove, or seem to prove, almost anything. We also know that there is such variability in human affairs that statistical probabilities and the law of averages cannot be universally and dogmatically applied to the single unit, but only to a mass of units.

When a philosopher can prove that a man pursuing a moving tortoise can never catch up with it and that a moving arrow does not move (Zeno did both), and another philosopher says that "one might also prove the contrary" (that the arrow moves) but that "it would be more difficult," then my poor wits really get befuddled! Such abstract conclusions are contrary to what I actually experience in perceptive reality. I see that the arrow actually started from one spot and reached another, and that the man did catch up with the tortoise and even passed it. Practically, it does not seem to matter whether it is claimed that things or individuals have no existence outside the mind, or whether mind itself exists, or what reason and intelligence are, if we are thinking in a cosmic sense. One thing I cannot conceive, and, therefore, cannot accept, is the validity of any such concept as there being *only* matter or *only* mind, or any other absolutist unipolar either-or view. I crave a synthesis, a reconciliation of opposites which can be rationally apprehended and maintained as having some definite relationship to experience—not just to "my" experience or to "yours," but to comprehensible universal experiences. We all know, I am sure, that we do not need to live every possible experience to be able to understand it in some degree, to accept the fact that it actually



happened to someone, somewhere, some time, and to be sorry for, or rejoice with, the one to whom it happened.

The synthesis that is of interest may be weighted in any direction. It may be primarily based on ethics, morals, health, science, logic, natural or supernatural phenomena; or on idealism, realism, dualism, materialism, psychophysical parallelism, or on any of a long list of ideas which men have ardently espoused and erected into systems. But the synthesis must include more than any one primary idea that is blown up to the point of being regarded as the ultimate or only solution or explanation of the universe, or the sole set of laws that govern phenomena and their interrelationships.

The one concept that is clear to me about life is that it is composite, complex, and variable. I cannot conceive a single, ultimate, cosmic, universal law. I can conceive of a system of laws that has some sort of common thread, which, nevertheless, permits the permutations and commutations that we see all about us, plus the many that we know or can prove by inference and by some sort of supportive evidence which is understandable. The kind of laws I have in mind even leave us the freedom to believe that there are things not yet discovered or even dreamed of, and that laws exist which we do not yet know. My concept is of a live, growing universe, especially perhaps, of knowledge and thought, and including the belief that man grows mentally, too, in irregular spurts. I can understand that matter exists in both static and dynamic forms. I can accept the evidence that inorganic substances undergo transmutation, though whether the process is spontaneous or must be developed and controlled by external agencies is not entirely clear. What substance and form and life mean to me does not necessarily indicate what they mean to any one else. We may agree, and the more we agree the more certain is the similarity of our mental processes, and of the shape, size, color, consistency, function, etc., of the observable materials. Because humans have imagination, they can create mental and verbal images of what are insubstantialities, at least so far as any direct sensory experience is concerned, and these may powerfully influence thought, emotion, and action. This is a fact to me because it is something I have observed in myself and in others. Even in philosophers.

To find good examples to prove the coexistence of determinism and freedom of choice, a synthesis of concepts in which I firmly



believe, has not been easy. I devoted a lot of thought to the matter, practically always on rather complicated problems, because I was also thinking of the interrelationship of responsibility. Then a very homely event provided a simple example which illustrates rather perfectly my conception of the relationship between determinism and free choice.

I developed a positive desire for an apple, just why I do not know. I am sure that there were many physiological stimuli arising in several areas. I will leave it to your imagination to enumerate the various sensory and motor nerve impulses that were involved in setting up a feeling of need for a particular something to ingest. I will also leave to your conjecture which and how many psychological associations and processes may have been set to work to eventuate in the ultimate mental representation or conclusion that I wanted an apple. This total process in which potentially thousands of minute bits were associating and reassociating must be a deterministic operation. In other words, arriving at that sort of conclusion is a simple and direct example of determinism. In the next act, that of selection, I see nothing deterministic. I went to the refrigerator and found three apples, none of which coincided with the apple I had mentally conjured up. However, each apple had certain different desirable characteristics. I had therefore to make a choice, which I did, not blindly but deliberately. Granted, had I been sure that apples were available, this might have been the fringe-of-consciousness initial stimulus which eventually forced the realization that I wanted an apple, yet the process by which the conclusion was reached is still determinism. The fact that there were apples was, as far as I am aware, fortuitous, but the choice was mine and a free one when I found them.

Then consider this. I like cheese with apples, and I spied two of my favorite kinds which I definitely had not known were available. I became aware then that I had another decision to make. Either I would not take any cheese, or I would take one or the other (and if so, which one?), or I could have some of each. There was still another decision to be made. Should I omit the apple and eat only cheese! The possibilities were quickly weighed, a conclusion reached and the act completed with an untrammelled feeling that I had made a free choice. (If you want to know what I did, I ate the chosen apple without cheese and with considerable satisfaction.)



Suppose, however, there had been no apples in the bin. Then three courses of action would have been open to me. I could have picked a substitute; I could have felt more or less frustrated and gone without any food; or, if the desire (drive, will) were strong enough, I could have gone in search of a fruit stand to buy an apple. But here again it would have been my own free choice among the alternatives. To sum up, the fact that there were alternatives seems to be an example of determinism, but the choice of the alternative is, in my judgment, a matter of free will. This may not be superior logic, but it fits the facts as I see them.

This admittedly naïve example led me directly to another combination of circumstances of definite psychiatric significance, about which I believe all of us as psychiatrists are in agreement. Every individual can react only within the limits of his biological capacities, as modified by development, frustrations, compensations, disease and accident. His reactive capacities are therefore determined for him. The factor of chance, over which the individual has no control, merely helps to complete the picture of determinism. But within the framework of the limits set by determinism, every individual has a wide range of freedom of choice, simply because there are always variations and, therefore, alternatives. Even in those things which are most rigidly fixed in terms of structure, there are still alternatives when it comes to the resultant action. We can walk backward as well as forward, or we can stand still. Most important, we can always find reasons for what we do or do not do. That our stated reasons may merely be camouflage for motivations which we wish to conceal seems to be further proof that we can and do make choices, which are free, between multiple alternatives with which we have at some time or other experimented. There is the additional fact that we can and do experience sharp pangs of indecision because of strong conflicting impulses to act, and that we may carry through a course of action even despite marked psychic pain or sorrow about the course we decide we *must* pursue.

We should at least glance at the concept of will as the final step in this attempt to demonstrate the actual compatibility of psychic determinism and freedom of choice. People are inclined to discuss the will and the idea of free will as a fixed, unitary concept, but it seems possible to demonstrate that this unity is far from being the case. Quite different meanings are attached to the word "will"



according to whether it is being used in ordinary conversation, is being applied in psychology and physiology, or is being debated by philosophers.

If bluntness can be pardoned about this particular issue, I would record my deliberate opinion that at least some philosophers have made a mare's-nest out of a matter which seems comparatively easy to resolve. This may seem a naïve statement, but I would support it by citing William James, who chose "the alternative of freedom" for "ethical rather than psychological reasons," having stated flatly that the "question of free-will is insoluble on strictly psychological grounds." James points out that determinism is only "a clear and seductive conception" which one *must* espouse if he accepts the "great scientific postulate that the world must be one unbroken fact, and that prediction of all things without exception must be ideally, even if not actually, possible." A moral postulate which he outlines would lead one to espouse the contrary view. He concludes that "when scientific and moral postulates war thus on each other," and there is no objective proof, then the "only course is voluntary choice, for scepticism itself, if systematic, is also voluntary choice."

This passage bothered me, since James was both a competent physiologist and an extraordinary psychologist. But the thought occurred that he was being theoretical rather than scientific, and perhaps even a bit of a mystic. What it seems that James overlooked here (and I may have missed something myself) is the simple factor of individual, human psychology.

One wonders how far we do actually order our lives on postulates, or on ideals alone. Can the world—the great cosmos, the ultimately unknowable, at least illimitable—actually be one "great unbroken fact"? What sector of the universe do we, any of us, worry about? I doubt that any of us feel, or think, or judge, that we have had *no* opportunity to choose a course of action. We have all been confronted with alternatives, and we have all had to make choices, sometimes painful, sometimes pleasant. Granted that the choice was determined by the total configuration of our personalities at that point, and that we could not have made a different decision *as we saw the matter at the time*, do we honestly feel that we could not possibly have made any other decision? I believe that our insight, our auto-criticism, tells us that we have not only frequently done the inevitable in terms of accumulated pressures,



but that we have also frequently done some sidestepping. Are we to accept plaudits for our good decisions and blame fate or the devil for our bad ones? Are we any more or less responsible for the one than for the other? We can only decide and choose and act in accord with what we are at a given time. What we are is determined by all of our past experiences, our stage of development, and our potentials. Man in the mass may follow deterministic paths, but man the individual is different.

Because we are living creatures, with complex minds full of desires and purposes, aims and objectives, frustrations and compensations, we find all manner of means in which such a dynamism as desire (one of the definitions of will) operates in the selection and formulation of our perceptions, ideas, memories and, eventually, actions. We analyze, that is, proceed from a whole to its parts, or, in another idiom, we disassociate ideas aroused by perception; we associate them with other wholes or parts according to our purposes; we recombine parts into new wholes; or we reassociate through reasoning in which we weigh alternatives, use our imaginations, and devise methods for satisfying our inner drives. Our ultimate purposes seem to be subject largely to determinism, but how our deterministic synthesis finally becomes effective is a matter of selection for which we are the responsible agents. Since no psychic experience is ever completely lost, even though repressed into the unconscious, and mental life is continuous (the great discovery of this century), it seems inevitable that there must be determinism and also choice. There are entirely too many mental variables, too much content both conscious and unconscious, for any other conclusion to be tenable, at least to me. That freedom of choice is hampered or deflected by complexes and conflicts, by neurotic compulsions or psychotic reasoning, is perfectly true. This is only another example of the fact that our freedom of choice operates only within the framework of our total personality potential. It does not change the factor of multiple choice; it merely emphasizes some of the limitations imposed upon our ability to exercise the freedom constructively.

If then, psychic determinism and freedom of choice are not incompatible, but do actually operate in conjunction, what about responsibility? The only way I can approach this is by considering two widely separated aspects of responsibility. The first is the legal concept, as exemplified in the criminal law with reference to



mental irresponsibility as a defense against a criminal charge. The other aspect is that of the individual's own feelings of responsibility, and in this connection I shall use guilt as an example and discuss it very briefly. Responsibility is a word used in many connections, but the two senses chosen here seem to offer the best possibilities for expounding the special relationship now under discussion.

The legal concept of responsibility for criminal actions is really much more confused than seems to be generally realized. The law makes a great point of willful acts which are contrary to the legal code. But under certain circumstances, as with the feeble-minded and children under 15 or 16, according to state laws, an Aristotelian concept appears to operate; that is, the will does not function in accordance with what reason holds to be good or bad. In other words, these groups plus the intoxicated and the insane "do not know the difference between right and wrong" and, by extension, the implication is that the will is disordered. Or, in terms of the concepts I am advocating, freedom to choose the right (in this case the legal) course of action is impaired to such an extent that the individual is not responsible before the law. This sounds as absolutist as many philosophical systems, yet look at the exceptions and watering-down shown in the grades of homicide, of larceny, assault, robbery and other crimes, and the variations in punishment. Or, on the psychiatric side, observe the legal acceptance, at least at times, of the idea of "the irresistible impulse," the type of obsessive-compulsive neurotic activity with which the psychiatrist also deals in non-criminal cases.

I believe two factors strongly influence the legal attitude. One is called "extenuating circumstances"—a recognition of the fact that external provocation can reach a point where any ordinary individual will react with hostility and aggressive acts. Psychiatrists would grade such circumstances by knowledge of the individual's personality; but the law operates in terms of some hypothetical averages as to people's limits of endurance. The second factor, an individual psychological one, involves the defendant's concepts of right and wrong, as shown by the sort of self-justification advanced for the acts, plus absence or evidence of guilt feelings about the acts. Judges have great difficulty in understanding the psychodynamics of the psychopath, or accepting the psychiatrist's often rather labored attempts to explain them. The courts



also have their own standards for diagnosing "insanity." I have been told by judges, even recently, that they hear psychiatric testimony only because it is the law, but do not allow the testimony to influence their own decisions.

Delinquent and criminal behavior may be the norm of behavior for people who have been reared in certain ways. Much anti-social behavior is based upon major or minor mental disturbances, but some of it is due to archaic or anachronistic laws. Samuel Johnson is quoted as saying, "The law is the last result of human wisdom, acting upon human experience for the benefit of the public." This would both make the law a great abstraction and remove it a long way from the individual, as though he were an unimportant unit of "the public." I found this sentence in a recent law publication: "To continue to follow a right and wrong test enunciated in 1843 [the M'Naghten case] despite the growth of psychiatry would mean that the Common Law is unable to adjust its rules to medical knowledge." This, of course, refers primarily to legal insanity as a defense against crime. If we, as psychiatrists, regard recidivists as being in greater or lesser degree mentally sick, even though not insane or feeble-minded, then we must stand for a concept of limited or qualified responsibility, and believe that the framework of determinism is pathologically altered so that freedom of choice is impaired. There is one final point to be remembered here. What constitutes legal offenses against society, and what represents adequate punishment therefor, vary within wide limits from time to time in the same community, and at the same time in different communities. Even though these variations may be slow in evolution, they do affect both individual and legal ideas of responsibility.

With regard to personal guilt feelings, it is the capacity of a person to experience guilt feelings that helps so much to convince me that psychic determinism and freedom of choice must co-exist; because guilt, the impact of the super-ego or conscience on the choice of actions, keeps the individual from merely reacting reflexly and hedonistically to stimuli. Guilt is involved in the sense of responsibility, not only for the person's own actions, but for others and for his relationships with them. The over-all picture is that of the super-ego battling with the egocentric id impulses. The super-ego and the guilt feelings may be pathological in strength and impair the freedom of choice, a familiar psychiatric



picture, but that is not the point just now. Without a normal quantum of guilt feelings, I cannot see how we could develop a balancing humility, a sense of responsibility for our own actions, a constructive feeling that we *do* have freedom of choice, and the driving force to strive to reach our ideals. That the super-ego and guilt feelings are first elaborated for us and stimulated from without is beside the point here. It is their incorporation and elaboration within our own conscious and unconscious that makes them so very important. To think through what such a synthesis can mean to each of us, we must inevitably include its meaning not only in secular matters and in our clinical work, but also in terms of our fundamental beliefs.

If I have managed to present a reasonably clear account of what I understand and think as a clinician about determinism and responsibility, then I have indeed achieved a considerable measure of satisfaction.

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- Ford, John C.: *Depth Psychology, Morality, and Alcoholism*. In this excellent monograph, published by Weston College (1951), Father Ford presents an extensive review of the literature on depth psychology, with particular reference to its relationship to Catholic doctrines of faith and morals. His most important conclusion is to the effect that the moralist welcomes any light that depth psychology can shed on the effects of unconscious influences upon free or conscious decisions. This writer found his discussion a very illuminating critique of the several concepts of the unconscious and its relationships to the conscious. It helped greatly in the final synthesis of the positive compatibility between determinism and free choice. Father Ford emphasizes in several ways the fact that moral responsibility in the mentally disordered is to be considered in a quite different light than in normal people. I have gained the impression that Father Ford, in common with clerics of other faiths with whom I have talked, or whose writings I have perused, recognizes that morbid doubts, compulsions, anxiety and guilt feelings not only exist, but that they impair freedom of choice and action. By "morbid," I mean uncontrollable thoughts and feelings and impulses to action that dominate attitudes, and pre-empt the field of consciousness to a degree which interferes with or abolishes those rational processes which are necessary to achieve a balanced



relationship with reality. A simple example would be that of persons with such a morbid fear of crowds and enclosed places (pantophobia and claustrophobia), and such people certainly do exist, that they could not even go to church. Yet a church and religious services should, according to all our ordinary ideas, be safe and comforting. Father Ford seems to see what is perfectly clear to the writer as a psychiatrist, i. e., that a mental disorder, whether it amounts to "insanity" or not, impairs freedom of choice, and therefore responsibility. I cannot be sure that Father Ford would agree with me that this impairment of freedom of choice is primarily related to an underlying pathological deviation in the complex of factors which make up the mental set; that is, that delimit and circumscribe the elements in psychic determinism of the particular individual at some special time. But it seems clear to me that Father Ford's general point of view is that freedom of choice, in whatever field it may be exercised, can only be operative within the limits of the individual's character and personality structure, however these may be determined and whatever pathology may modify them. I am also sure that Father Ford's point of view often differs from my own with respect to details, but I believe his general point of view is similar to my own.

James, William: *The Principles of Psychology* (2 vols.). Discussion of will and determinism will be found in Vol. II. The points which I have used as having special significance in the present discussion are on pp. 572 ff.

The citation from Samuel Johnson and the comment on Common Law and medical knowledge are from a bibliography of recent publications on "Insanity as a Defense to Crime," published in the March 1952 issue of *The Record of the Association of the Bar of the City of New York*.

A number of other works on philosophy and pastoral theology were consulted, but the foregoing represent references which seem the most pertinent to my thesis.



## THE CONCEPT OF THE UNCONSCIOUS\*

BY LUDWIG EIDELBERG, M. D.

The concept of the unconscious was introduced by Freud on the basis of the experiences he had gained while trying to develop a psychological method for the treatment of neurotics. Most of his contemporaries rejected his suggestion with scorn. Some of them tried to discredit the scientific character of his undertaking by pointing out that, as psychology had not been used before to deal with the problems of the unconscious, physiological methods should be employed for its study.

The importance of Freud's achievement is obviously not due to his decision to use the word "unconscious" but to his *discovery* of a psychological method which made the study of the unconscious possible.

Psychoanalysis, like other sciences, did not start its work with exact formulations of the technical terms it intended to use. Instead, on the basis of clinical experiences, certain ideas were described under names of which the meanings were kept vague purposely to avoid unnecessary rigidity.

Psychoanalytic terminology is, therefore, rightly compared to a filing system in which, not the title of the file, but its content, deserves attention.

Keeping this in mind, only a superficial and brief description of the terms used herein will be attempted by this writer. He cannot present a complete survey of all analytical terms and what they mean to different analysts, but he wants at least to indicate how he proposes to use them in this study.

According to Freud:\*\* "There is no need to characterize what we call conscious: it is the same as the consciousness of philosophers and of everyday opinion. Everything else that is mental is in our view of the unconscious." Having considered previously that "mental,"\*\*\* from an anatomic point of view is localized in the central nervous system, Freud then divides the territory of the unconscious as just defined into two parts: the preconscious and the un-

\*This paper will appear as a chapter in Dr. Eidelberg's forthcoming book, *An Outline of a Comparative Pathology of the Neuroses*.

\*\*Int. J. Psychoan., 21:40.

\*\*\*Int. J. Psychoan., 21:28.



conscious proper (able to become conscious and unable to become conscious).

The term "preconscious" describes all the material which, while unconscious at a certain moment, may easily become conscious as a result of the decision of the total personality to make it conscious. The term "unconscious," on the other hand is reserved for phenomena which under ordinary circumstances are unable to enter into the conscious part of the personality. The presence of these phenomena can only be inferred; and they can become conscious only after *resistance* has been eliminated.

While, from a theoretical point of view, it may be impossible to prove that all sensations originating in the central nervous system can become conscious, we know that some of them do, and that consciousness depends on many factors and varies with different individuals. Without setting limits to what can be examined by a psychological method, the analyst seeks to concentrate his work on the ordinarily inaccessible part of the unconscious, which can finally become conscious (after resistance has been overcome).

While Freud originally expressed the idea that whatever had become conscious and had been repressed could be recovered, he admitted in later years that some of the repressed material may be lost forever. The unconscious phenomena the analyst is interested in, are obviously the ones that are responsible for the presence of the defense mechanisms and that cannot merely be guessed or assumed but can also be demonstrated and eliminated.

The discovery of a method capable of giving entry to the hitherto unknown part of the human mind did not induce Freud to neglect the importance of consciousness: "But none of this implies that the quality of consciousness has lost its importance for us. It remains the one light which illuminates our past and leads us through the darkness of mental life."\*

Most of the critics of Freud's concepts of the unconscious failed to realize that his insistence on using a psychological method was based on the ability of this new method to translate unconscious material into conscious.

In his study of neurotics, Freud gained the impression that their symptoms were connected with such psychological phenomena as ideas and emotions of which they were not aware. While other doctors have accused neurotics of lying in order to fool the exter-

\*Int. J. Psychoanal., 21:84.



nal world, Freud discovered that they are actually fooling themselves. They are hiding, behind their symptoms, their "real" desires, but they are not aware of the game they are playing and do not have the power to uncover and to face the truth.

In addition to a deliberate lie created to protect one individual from another, an internal "lie" is thus discovered; it protects one part of the individual from another part. In this internal lie, the conscious part of the personality is separated from the unconscious. As a result, the satisfaction of drives that are present in the unconscious is interfered with because satisfaction can only take place through the actions of the conscious part of the personality. This separation of the unconscious from the conscious was at first regarded as responsible for an increase of tension in the unconscious. Later, however Freud recognized that a certain amount of instinctual discharge can be achieved in spite of the fact that the conscious part of the personality is separated from the unconscious part. It is now easy to see how this discovery led to the structural concept of psychic organization, a topic which will be taken up presently.

Continuing the discussion of the unconscious, it should be pointed out that the material of interest here, while no doubt also approachable by physiological methods, can be verbalized as: desires, needs, fears, tensions, etc., which, while unknown to the patient when he starts his treatment, do become conscious with the help of the psychoanalytic method.

The material gained in analysis consists of certain motoric actions which can be seen by the analyst or described by the patient, certain ideas which the patient can express and the analyst understand, and certain emotions which may be partly described by the patient and partly guessed by the analyst. By identification with the patient, the analyst is also able to experience certain emotions; but he must be careful not to project his own emotions into the patient and he must be aware of the fact that the presence of an emotion in himself is not a proof that a similar emotion, or any emotion at all, is present in the patient.

The idea that words and gestures can be used, not only to express our ideas and feelings, but also to hide them, did not originate with Freud. The concept of the ostrich burying its head in the sand has been familiar to mankind for centuries. But Freud was the first to develop a scientific method to prove that a neurotic



was not even master in his own home, that there was a part of him which he was not aware of, and that this part was able to fool him.

Independent of philosophical reservation, the word "unconscious" as it is used in analysis can be understood properly only in connection with concrete-clinical examples. If we talk about an unconscious wish we are aware of the fact that some part of this wish sooner or later will become conscious or become approachable by a psychological method. Therefore some authors, when they are referring to the unconscious, use the term "partly unconscious," in order to point out that the phenomena psychoanalysis is interested in can become conscious under certain conditions. (The term "partly unconscious" should not be confused with "pre-conscious" which can always become conscious.) Some patients, when told about unconscious wishes they are supposed to have, have the impression that these wishes will never become conscious and that they are not responsible for their presence. The words "not responsible" mean that such wishes are something they will never be able to influence; and such patients accept an analytical interpretation as if it referred to the number of red blood cells they have. But what is suggested in analysis as being unconscious is something which although not "visible" to the patient at a given time may become visible later.

In psychoanalysis today, much more is known about pathological than about normal psychology. In other words, analysis is chiefly concerned with phenomena which "don't make sense," or phenomena which do seem to make sense to the patient but not to the analyst who, on the basis of the experience gained in other cases, expects to find the real explanations for such things in the unconscious.

One typical reaction of a patient to a suggestion that something is unconscious is to accept it at once and to use it in order to avoid responsibility for his problems. If it is true—he argues—that this symptom was created by a part of him he is not aware of, obviously he cannot be expected to do anything about it. In taking this attitude he seems to support the critics of psychoanalysis who condemn it because it gives the patient permission to "enjoy" his illness, free of feelings of guilt.

This is an error! The patient (not the critic) will discover in his analysis that the analytic treatment, while freeing him from suspicions of having consciously created his symptoms to avoid



his social responsibilities, is aimed toward having him conquer the neurotic products of his unconscious. Without blaming the patient for his errors of the past, the analyst will try to show him that it is up to him to utilize his new insight, not only to explain what has happened in the past, but also to prevent it from happening again in the future.

The following example may be used as an illustration of what has just been said: For one of the writer's patients,\* psychoanalysis meant freedom to say whatever happened to pass through his mind and he thought that, by exercising this freedom, he would finally be cured. To eliminate his resistance, the writer had, at first to make him recognize that his endless talk did not represent acceptance of the basic analytical rule. For a long time he refused to face what he was saying because he was afraid that, after understanding it, he would have to remain silent. The writer had to prove to him that he enjoyed talking and that he was afraid to admit it. His talking meant not only: "I love, hate, suck and swallow my mother," but also, "It is not true that I have such desires, the truth is that I am interested in being cured by analysis." In that way, his uninterrupted talk served the satisfaction and the rejection of sexual and aggressive impulses. The unconscious responsible for the defense mechanisms is neither a philosophical concept nor an anatomical organ over which we have no control, but a part of us which has lost its conscious quality. This conscious quality can be regained with the help of analysis.

The analyst tries to show the patient that instead of accepting punishments connected with the toleration of neurotic symptoms, he may destroy the symptoms by finding their unconscious meanings.

The analytical aim is to help the patient substitute a conscious solution for an unconscious one. Without trying to interfere with the patient's habits, character and philosophy, the analyst wants him to face the truth, the internal as well as the external one, and to make his decisions on the basis of what he knows, so he can obtain what he wants.

Just as a district attorney would not throw away a code letter found in the possession of a suspect merely because it did not contain a frank confession of crime in plain English, the analyst

\*Eidelberg, L.: A contribution to the study of resistance. *PSYCHIAT. QUART.*, 26:177.



should not expect to receive unconscious material undisguised. Instead he will have to collect whatever he gets hold of, in order to establish a chain of circumstantial evidence leading to the neurotic symptom. The patient, in this simile, is not only the suspect, but he also plays the role of the jury and helps the "prosecuting" analyst to prepare his case. It is not surprising, therefore, that analysis can only be successful if the patient is interested in having his unconscious exposed and that analysis fails whenever his co-operation is refused. However, while the lawbreaking culprit whose responsibility has been proved in court must go to jail, the patient who recognizes his responsibility for his illness becomes free to leave his neurotic confinement.

The chief difference between a neurotic symptom and a normal act is the fact that in any so-called normal act, the individual is aware of what he wants; he remembers experiences he has had in connection with past attempts to satisfy such a want; he recognizes the limitations of internal and external reality; and, finally, after having reached a decision, he either proceeds to satisfy his wish or he modifies, or rejects it. In the neurotic symptom on the contrary the wish itself either does not appear at all before the conscious part of the personality; or, if it appears, memories of past experiences connected with it are blurred or not available, or the super-ego appears to be too severe or too lenient; and, finally, the external world is not seen as it is but as the patient would like it to be (unconsciously). The facts that the patient keeps from his conscious mind, and his ability to deal with certain wishes without becoming conscious of them, are responsible for the neurotic solutions he reaches.

As has already been said, the discovery of the psychoanalytic method has taught us how to bring, into the open, ideas and feelings the patient is not aware of. The patient's ignorance is not caused by lack of intelligence or bad memory. The material responsible for his symptom is unknown to him because he has pushed it into his unconscious and has insisted on keeping it there. The neurotic symptom is the result of a fight between a wish that is trying to become conscious and the patient's refusal to face it.

The division of personality into a conscious and an unconscious part represents the systematic approach, whereas the description of the neurotic symptom as resulting from a conflict between these two parts of the personality is referred to as a dynamic approach.



After Freud had recognized that a defense against the derivatives of the unconscious could not be described as conscious, he introduced the topographical or structural approach. In addition to the division of the mental apparatus into the systems of conscious and unconscious, Freud divided the total personality into three parts. The boundaries of the three parts, the id, the ego and the super-ego cut partly across the old lines separating the systems of the conscious and the unconscious. The id is described as totally unconscious, whereas the ego and the super-ego are partly conscious and partly unconscious.

This new division of personality permits description, not only of demands from the id, but also of defense against them by the ego, as unconscious.

While the former differentiation by systems does not lose its heuristic value, the newer concept allows a better understanding of the subject of this research because it allows description, not only of the repressed, but also of the repressing factors, as unconscious.

The id contains the instincts which represent the *vis à tergo* responsible for all our activities. It can only be examined through study of the so-called derivatives of instincts which are formed after instinct tension has passed the ego-threshold. The id has no connection with the external world and opens toward the ego. The id is interested only in the discharge of instinctual tension but is unable to provide this discharge. Its activity is governed by the so-called primary process. The differentiation between good and bad, between yes and no, the recognition of time and space, are not present in the id.

Under the influence of the external world, part of the archaic id became the ego which controls motility, examines the external world and represents a link between id and super-ego. The ego may try to eliminate the unpleasure of increased tension by a wish to discharge it. As wishing alone is unable to provide such a discharge, the ego discovers that an external object and a motoric action are necessary if instinctual unpleasure is to be eliminated. The ego may also decide not to eliminate the instinctual urge but to endure the unpleasure. The super-ego represents the moral part of the personality. It is the result of identification with the parents or their super-ego. As a result, it observes, gives orders,



sets up prohibitions, and praises the ego.\* While the super-ego of a child, the so-called infantile super-ego, represents a foreign body, containing the admonitions and prohibitions experienced by the child, the super-ego of a normal adult is completely assimilated. The individual has selected, among the orders he has received, only the ones he considers justified and has blended them in such a way that they represent part of his own personality.

A survey of the psychoanalytic literature (including the papers of this writer) shows that the term "ego" is used not only to describe one part of the personality but also is employed where acts of the total personality may be involved. For instance a symptom is described as containing elements of id, ego and super-ego; and the reaction of the patient to his symptoms is referred to as ego-alien, although—to be exact—it may be alien, not only to the ego of the patient, but to his total personality.

Students of the psychology of the normal individual may consider this division of the total personality to be an unnecessary complication of their work, and may complain about the difficulties connected with the separation of the three parts of the personality from each other; in pathology, however, the topographic (or structural) approach has proved its value.

Using a topographic presentation of the act of eating by a normal individual as an illustration, one may say:

As a result of the accumulation of certain metabolites and the loss of others, an instinctual tension is mobilized in the id, is recognized by the ego and is experienced by the total personality as a feeling of hunger. The experience of hunger may take place in the total personality which, through its ego, remembers having experienced similar feelings before, and remembers having discovered external objects and proper methods to eliminate this hunger. "I feel hungry," changes into "I want to eat." Again with the help of the ego, a plan to find food, to incorporate it, is made and presented to the super-ego. If approved, this plan may be executed, the food incorporated and the hunger satisfied. In cases where no food is available or where the time and energy required for eating are needed for other purposes, the total personality may postpone the satisfaction of hunger. As a result of such a decision, the wish to eat may be suppressed (not repressed). The knowledge that one is hungry and desires to eat may disappear for a certain

\*Freud, S.: *Int. J. Psychoan.*, 21:75.



time. Something similar may take place if the super-ego rejects the wish to eat. The suppressed wish will become preconscious and regain its conscious quality whenever the total personality decides to allow it. However, the hunger may last too long for the total personality to suppress it.

This is a schematic presentation of how the three parts of the personality function (in case of hunger) under normal conditions.

Under pathological conditions, however, a wish representing instinctual tension cannot become conscious because the ego blocks its entrance into consciousness. As a result of this blockade, however, the part of the ego used for the blocking purpose becomes unconscious. Presently instead of the repressed wish from the id and the repressing ego entering the conscious mind, something which contains elements of both will enter.

According to the unpleasure-pleasure principle or its modification, the reality principle, the individual tries to overcome unpleasure and obtain pleasure—any pleasure at once, or a better, safer pleasure later than can be obtained at once. However, he is often unable to achieve this goal. The object he is looking for may not be available or the enemy is stronger than he anticipated and defeats him. He fails at arriving at a harmonic compromise of his various desires, they contradict each other or his super-ego produces feelings of guilt. Consequently, instead of achieving pleasure, he suffers unpleasure. He may now avoid this unpleasure by repressing the knowledge of it. In that way two forms of repression may be differentiated: (1) repression by the ego, trying to ward off the derivatives from the id or super-ego; (2) repression by the total personality, trying to eliminate the consciousness of the “foreign body” representing the repressed and the repressing factors.

In addition to the mechanism of suppression which allows the total personality to avoid, for the time being, the feeling of unpleasure, the mechanism of repression seems to protect the personality from the experience of unpleasure for an indefinite time. However, this mechanism of repression may be activated *only* under special “traumatic” conditions.

If the individual were omnipotent he would have the power to stop any unpleasure immediately after he experienced it. But as he is not omnipotent the fact that he often suffers unpleasure is not a contradiction of the pleasure principle.



Obviously there are two ways to remove unpleasure: (1) to obtain the external object necessary for instinctual satisfaction; (2) to eliminate the knowledge of unpleasure. The latter possibility will be discussed here.

While it is generally accepted that the ego is able to control the id by mobilizing a so-called opposite instinct fusion or by turning the instinct fusion against the self, it is not clear what makes the difference between a normal and a neurotic use of these two mechanisms.

It may be assumed that the derivatives of the id are reaching consciousness if their energy cannot be discharged without a co-ordinated action of the total personality. In other words, the act of consciousness seems to take place whenever an unconscious discharge of instinct-tension becomes impossible. In this respect, the act of consciousness represents an improvement in the method of discharge of instinct-tension and takes place in order to achieve such a discharge. If this statement is correct, any inhibition of the act of consciousness would prevent or delay instinct satisfaction and would take place whenever instinct satisfaction became dangerous. One could then arrive at the conclusion that inhibition of the act of consciousness takes place to prevent instinctual discharge, if this discharge represents a threat to the individual. Before accepting this statement, it must be remembered, however, that the act of consciousness, while serving or facilitating the discharge of the instinct-tension, is not identical with the act of discharge. After unconscious derivatives become conscious an individual is *free* to decide whether a discharge should or should not take place. In other words, instinctual discharge can be stopped in spite of the fact that tension has become conscious (Condemnation — *Verurteilung*). Therefore the suggested conclusion that the inhibition of the act of consciousness takes place to prevent such a discharge was incorrect. Furthermore, it is well-known that an instinctual discharge may take place without its need becoming conscious and that the act of consciousness may lead to a conscious repudiation of the previously unconscious discharge. In other words, the act of consciousness may be used to facilitate, or to prevent, an instinctual discharge on a level on which the individual is aware of what takes place.

What are the advantages of an instinctual discharge either being stopped or taking place on a conscious level, as compared to



the unconscious one? Finding an object, selecting time and way, directing the "aim" in which the satisfaction takes place, co-ordinating the actions required, utilizing memories of former satisfactions, and anticipating future satisfactions, are characteristic of activities on the conscious level. On the other hand, an unconscious discharge or inhibition will take place without the benefit of these elements.

In comparing the conscious and unconscious methods leading to instinct satisfaction one has to remember that the act of consciousness is not a pure intellectual process but that it often contains, in addition to intellectual elements, the emotional sensation of pleasure or unpleasure. The unpleasure is, first, a signal calling for attention by the individual and informing him that his instincts call for discharge; second, it is an emotion he experiences when he remembers previous frustrations and anticipates new ones. If he is able to find the external object necessary for his instinct-satisfaction, his unpleasure will be of short duration. If, however, an external object is not available and an instinctual discharge is impossible (even if one modifies his aim in accordance with external reality), the act of consciousness seems to have no advantage whatsoever. Therefore, it appears that, under such conditions, the act of consciousness will only lead to the experience of unpleasure and will therefore be avoided. As long as there is a possibility of satisfying instincts by modifying their aims or by changing external objects, it "pays" to use the act of consciousness for the selection, guidance and control of impulses. If, however, a modification of aims or change of external objects cannot supply the instinct satisfaction, one may use the mechanism of suppression, by which a conscious elimination of the unpleasure takes place for the time. As a result, the knowledge of the presence of certain emotions, ideas and sense-organ perceptions is avoided. However, this relief is temporary in nature. It appears that suppression is the act of the conscious part of the ego, repression an act invoked by the unconscious part of the ego. In suppression, unpleasure is not only avoided, but the recognition that something has to be avoided is kept from the ego.

According to Freud, the ego has the power to avoid the unpleasure connected with consciousness of the needs of the id, with admonitions and prohibitions of the super-ego and with demands from the external world. It does so by withdrawing the energy



attached to unpleasure-producing representatives. This is achieved, under normal conditions, by the mechanism of *suppression* which, because it takes place on a conscious level, remains reversible.

However, while, in the case of *suppression*, the libido (or destrudo) is transferred from the unpleasure-producing representatives to others which promise pleasure; such a transfer of libido probably does not take place in the case of *repression*. Clinical experience seems to show that repressed impulses retain their libidinal charge. This leads to the question about the method by which the neurotic defense mechanism keeps highly charged derivatives from becoming conscious.

The energy of the instincts used by the neurotic defense mechanisms for contracathexis is used to keep the energy of the repressed wish from becoming conscious, but it is not quite clear why the energy used for the purpose of defense also remains unconscious. To understand the "iron curtain" separating the conscious part of the ego from the unconscious, one must look for a dynamic factor.

A survey of the psychoanalytic literature shows that some authors assume that the so-called death instincts (not the pure death instinct, Thanatos, which according to Freud is silent) are present in the neurotic defense mechanisms. Under the name of death instincts, they describe all the impulses which instead of being directed toward the external world are turned toward the self. This is particularly clear in the case of aggressive instinct fusion. But even in certain examples of self-love, in which the individual gives up all external objects and concentrates his whole libido on himself, final destruction of the individual takes place. From the point of view of economics, some psychoanalysts assume that when the instincts are turned against the self as a result of a neurotic defense mechanism, object libido (or destrudo) does not change into secondary narcissistic libido (or destrudo) but regresses to the primary narcissistic level.

However, most psychoanalysts agree that the study of the various neurotic defense mechanisms shows that the patient treats an external object as if it were part of his own body and his own body as if it were an external object. Metapsychologically, this is expressed as follows: The representatives of the body are cathected by object libido (or destrudo), the representatives of external objects are cathected by secondary narcissistic libido (or destrudo).



This seems to be the result of the mechanism of regression and fixation which is described by some authors as one of the unconscious defense mechanisms. Independently of this terminological question, most psychoanalysts agree that whenever a repression or a denial takes place, the libido (or destrudo) of the warded-off derivative becomes fixated, or regresses to an even earlier stage of development. If, for instance, a child experiences a trauma during the phallic stage, his libido may either become fixated to this stage, or it may retreat to the anal stage and become fixated there. As a result of regression and fixation, the libido does not progress to the next stage of development. A patient of the writer's, who had preserved in his unconscious an infantile oral wish, wanted to satisfy his hunger by devouring the breast of his mother and expected to achieve this aim by merely wishing. As a result of this unconscious wish and the defense against it, he used to suck his tongue. In that way, he behaved as if his tongue were an external object. At the same time, he treated his girlfriend as if she were part of his body. Whenever she disagreed with him, he felt as if he were paralyzed. He expected her to be able to "read" his thoughts and fulfill all his wishes at once.

This writer is in agreement with analysts who differentiate between unpleasure due to tension caused by a sexual instinct and tension caused by an aggressive instinct. A boy who insisted on eating his sandwich during a school lesson instead of during the recess did it not because he wanted to gratify his sexual oral wishes but because he suffered from having to obey and wanted to eliminate this unpleasure by defying his teacher.\*

A patient who objected violently to lying down on the couch and enumerated all the reasons against it, lay down at once when the writer succeeded in interrupting his tirade by saying that he might remain seated. It seems that whenever aggression is involved, being forced, or forcing somebody, becomes an important aim.

In translating unconscious material into conscious, one must, therefore, show the patient, not only what he wants, but also how he intends to get it (by force or by agreement).

To the psychoanalyst, it appears as if there were two ways of living one's life. A way often referred to as rational is the way

\*Eidelberg, L.: The Attraction of the Forbidden. In: *Studies in Psychoanalysis*. P. 129. Nervous and Mental Disease Monograph 75. New York. 1948.



in which one tries to recognize the internal and external facts and arrive at decisions on the basis of knowing what can be known. The other way of life is the neurotic one, in which a person *avoids* the knowledge of certain facts (genuine lack of knowledge must be, of course, distinguished from lack of knowledge caused by repression and denial).

Comparing the two methods, it seems that the former (rational) method increases the chances of optimal satisfaction at the price of experiencing temporarily the unpleasure caused by the *knowledge* of certain facts which the latter procedure seems to avoid perceiving. From a scientific point of view, the first method appears to be the better one, because the scientist refuses to live in a fool's paradise, having decided arbitrarily that knowledge is of supreme importance. The therapist who uses science to help the sick is also in favor of the first method, because, as a result of his experiences with his patients, he has the impression that the amount of unpleasure they avoid by being neurotic is smaller than the pleasure they miss. He is, however, prepared to admit that his statement holds true only in cases of patients who have been cured, and he accepts the idea that some patients may be wiser to refuse to seek his treatment.

According to Freud, repression is the mechanism which eliminates the knowledge of unpleasure from within, whereas denial frees us from the unpleasure caused by sense-organ perception. However, only the so-called successful repression can eliminate the knowledge of unpleasure completely. Wherever such a repression takes place the analyst will find nothing to examine. As a result, all the subjects of analytic studies are cases in which repression was not "successful."\*

Nobody has, as yet, explained why in some cases the repressed wish remains completely "invisible" (successful repression), whereas in others it succeeds in appearing on the surface in a kind of disguise. It may well be that quantitative factors play a decisive role. In this connection, it may be necessary to point out that Freud called repressions successful only if, in addition to psychic derivatives, the so-called somatic ones were also missing. One may also add that the analytical method is unable to prove that a "successful" repression can exist at all.

\*It is problematic whether "successful denials" are possible.



The outside world raise objections only to the motoric discharge reactions in the child and does not concern itself with his ideas and affects. It is probable that, ontogenetically and phylogenetically, action precedes ideas and affects. But analyzing, in a slow-motion view, the process in which a wish becomes conscious, and referring to the moment when the three derivatives have been formed one may say: "At first the individual feels unpleasure, a sensation of tension; then he becomes conscious of its sexual or aggressive color; then there emerges the idea of the object capable of removing this tension and the idea of the action that leads to this goal. The unpleasurable sensation of tension is then replaced, by way of anticipation, with forepleasure. Finally the action takes place, if it achieves the desired goal, the tension unpleasure subsides and the end pleasure appears."\*

It is assumed that the ego controls the entry of the derivatives of the id into its territory and tries to select among them the ones whose discharge promises the experience of pleasure or happiness.\*\* This function of the ego takes place with the help of the pleasure-unpleasure signal. Whenever a discharge of an instinctual tension may lead to a punishment from the external world or the super-ego, the ego may block the entrance of impulses from the id. By this, we mean that the ego tries to find an object which would, not only serve instinct gratifications, but produce pleasure, be accepted by the super-ego, and be permitted or offered by the external world. Instinct satisfaction may—and often does—take place in spite of objection by the super-ego and prohibition by the external world. As a result of the former, the individual must accept feelings of guilt, while the latter leads to external conflicts and possible punishments. Although, in such a case, total pleasure is diminished, or the pleasure gained is mixed with the unpleasure connected with guilt feelings and with persecution by the external world, many individuals accept this solution. The psychoanalysis of such individuals shows that they behave in that way because their super-egos object to all forms of instinct satisfaction; or they are not aware that modification of their aims or change of their objects may allow the experience of legitimate pleasure.

\*Eidelberg, L.: *Studies in Psychoanalysis*. P. 116. *Nervous and Mental Disease Monograph* 75. New York. 1948.

\*\*Eidelberg, L.: *In pursuit of happiness*. *Psychoan. Rev.*, 38:222.



The following process takes place whenever, as a result of the repression, the total personality is split in two and the repressed material cannot enter the conscious mind:

The part of the ego dealing with the forbidden wishes becomes separated from the conscious part or is overrun by the id. From an economic point of view, psychic energy is mobilized and used, not to deal with the problem, which remains unsolved, but to hide it.

According to Freud the trauma responsible for the act of repression (or one may add, that of denial) usually occurs in childhood. Whenever an external or internal stimulus threatens to destroy the mental apparatus of a child these mechanisms of repression and denial may be used as a protection. Consequently most neuroses, even if they develop in grown-ups, are generally regarded as caused by infantile experiences. The traumatic neurosis, however, which may be due to a particularly severe shock an adult has experienced is not necessarily caused by an infantile trauma.

The study of all neurotic symptoms shows the presence of an unsuccessful repression or an unsuccessful denial. It seems that whenever a traumatic wish is repressed or a traumatic, sense-organ perception is denied, something else appears. For instance little Hans\* succeeded in repressing his hatred of his father; but, instead, he had to accept his hostility against the horse. A manifest homosexual\*\* may succeed in denying the existence of female breasts, but he has to accept, instead, a passionate interest in the penes of other men. A fetishist\*\*\* may deny the lack of a female penis but has to use a fetish to overcome his fear of the vagina.

In other words repression and denial help us to avoid the knowledge of one unpleasure by accepting the presence of another one.† The fact that a patient may fight for many months to avoid the acceptance of an interpretation, in order to protect himself from the unpleasure connected with it, while, at the same time, he is willing to suffer the unpleasure from his symptoms, can usually only be believed after one has seen it.

The neurotic is not a coward, unable to take the unpleasure a normal person would accept. The unpleasure he avoids, often re-

\*Freud, S.: *Gesammelte Schriften*.

\*\*Eidelberg, L.: *Studies in Psychoanalysis*. 2d edition. P. 3. International Universities Press. New York. 1952.

\*\*\*Freud, S.: *Gesammelte Schriften*.

†Eidelberg, L.: *Studies in Psychoanalysis*. P. 172.



ferred to as traumatic, had, in his childhood, the power to injure, or even to destroy, his mental apparatus. This kind of unpleasure can produce a shock that may lead to loss of consciousness or even death.

The unpleasure the patient accepts instead of the traumatic one he avoids, was "created" unconsciously by the patient himself and, therefore, protects his infantile megalomania.

It may be difficult to believe that fears experienced in childhood should have the dynamic power to produce a neurosis in an adult or to disturb the sleep of a normal individual seriously. Only analysis can help the individual to recognize that a part of him never grows up, and to appreciate how much of his energy is needed to control his primitive instincts. A patient of the writer's, a well-to-do man and the president of a large company, was afraid for many years to enter by the front door, the building in which he lived. Only in analysis did he become aware that the doorman he was afraid of had no power over him. But as long as he kept on using the doorman as a symbol who represented his father when he was a child, it was very difficult for him not to use the back entrance.

It is impossible to describe the mechanism of repression without mentioning two phenomena which take place in each analysis and which appear responsible for mobilizing the emotions of the patients. They are the transference and the resistance.

According to Freud, transference is a term that covers all the emotions the patient has for his analyst. The survey of the psychoanalytic literature shows that, while some analysts use the word, transference, according to Freud's suggestions, others reserve it for only the emotions connected with the infantile wishes of their patients. These analysts assert that such a differentiation allows the separation of the normal adult feelings of patients—based on present reality—from the emotions due to revival, in the analytic situation, of infantile repressed wishes.

Such a use of the term has the advantage of showing to the patient the part of his personality which has remained infantile and is causing trouble. The patient's recognition that his complaints or desires are not based on what is going on in analysis but that they are expressions of the needs he had as a child will help him not only to recognize part of his unconscious but will also induce him to try to repudiate it.



A woman patient complained because the writer refused to lie down on the couch and have sexual relations with her. At first, she regarded her emotions, caused by the analyst's objections to such an activity, as based on the reality that she had as analyst a man who despised her. When it was pointed out to her, however, that acceptance of her suggestion would probably embarrass her because she was in love with her husband and that she would not want to change her analyst, she produced more associations to the frustration she suffered. In connection with a dream, she remembered how she had suffered while watching her mother feeding a younger brother and she realized that she wanted the analyst to nurse her. As the writer was not only unwilling, but also unable, to play the role of a wet nurse she had to admit that the rejection she had suffered was caused by her insistence on repeating the old conflict in analysis. We owe to Freud the insight that the patient either remembers his traumatic experiences, or repeats them in analysis, or tries to act them out in the external world. For instance a student of the writer's, who, while working with patients, continued his analysis, got concerned one day about the analytical progress of a friend whom he had originally recommended to a colleague of the author. Without discussing this problem with the author, he called up his friend and told her that as she was still not through with her treatment, she should change her analyst. As his friend resented this kind of interference and advised her caller-student to discuss his uncalled-for activity with the writer, it became evident that the advice he had given to his friend was meant unconsciously for himself.

Another patient of the writer's remained silent for quite a while after he had criticized the Viennese cuisine severely. At first he felt that his silence was caused by his justified anticipation of the writer's anger as a result of his criticisms. However, after the analyst had succeeded in proving to him that there was no reason to assume that he was angry, the patient said: "Still I will not open my mouth." At the same time he put his hand on his nose. A few days later, in connection with a dream, he recognized that the act of putting his hand on his nose represented something his mother did when he refused to open his mouth to be fed. By closing his nose, his mother was able to force him to swallow the food she gave him. The situation was repeated in analysis in order to express



fear that the analyst would force him to accept analytical interpretations.

While some analysts use the term, "counter transference," in connection with the feelings the analyst experiences for his patients, others prefer to speak of counter transference only if infantile repressed wishes are involved.

Although the ideal analyst should be free from all infantile feeling, experience shows that this goal is difficult to achieve and that analytic work may mobilize unconscious wishes which otherwise might have remained dormant. Whenever this takes place, the analyst should recognize it and analyze it himself or ask a colleague to do it. A short example as an illustration may be helpful: A female analyst who was treating a patient suffering from *ejaculatio præcox* forgot her appointment twice when the condition of her patient began to improve. She analyzed her parapraxia and discovered that the restored erection of her patient had mobilized her own, still unsolved penis envy. As a result, the continuation of the analysis of her patient meant that she would be having sexual intercourse with a woman through an unconscious identification with him. Against this forbidden homosexual satisfaction, she fought by mobilizing an unconscious hostility against her patient. After she had recognized the cause of her trouble, she managed to finish the analysis successfully.

While some psychoanalysts use the term, "resistance," for the power which interferes with the progress of psychoanalysis, this writer is in agreement with others who regard resistance as a mechanism which also operates outside the psychoanalytical treatment and prevents the consciousness and assimilation of repressed material.

While transference is analyzed only after it interferes with the progress of analysis, and counter transference is dealt with whenever it is recognized by the analyst himself or his supervisor, the unrelenting analysis of *resistance* represents the most important factor in the analyst's daily work. In analysis, the unconscious material of the patient becomes available only after the power responsible for keeping this material unconscious has been eliminated. This power, named "resistance," must be overcome before real unconscious material can be obtained. The well-known fact that some patients seem to be conscious of their infantile wishes, and have no resistance against their recognition and gratification,



is responsible for the erroneous conviction that such patients have no egos. While it is true that some perverts appear to be conscious of infantile desires and seek their satisfaction, while other patients reject such desires by repression, a closer examination shows that the wishes the perverts accept are not identical with the infantile wishes repressed by other patients. The perverts, too, repress their infantile wishes. The desires of which they approve are not infantile wishes but the results of a defense mechanism. Therefore, in the analysis of perverts, their resistance against their infantile wishes still has to be eliminated.

It is true, to be sure, that the elimination of the resistance of a pervert is technically more difficult than that of a patient suffering from a symptom neurosis. This is in accordance with Freud's statement that one of the most important factors responsible for the removal of resistance is the patient's suffering and his decision to terminate it.

While books on the technique of psychoanalysis describe in detail how this is achieved, it may be sufficient to say here that the analyst must change an ego syntonic defense mechanism into a foreign body.

To be effective, the act of conscious understanding must not only be intellectual, but emotional. Most analysts agree that there are many stages or degrees of such understanding and that only after resistance has disappeared, can one feel that the patient has fully attained it.

The analysis of resistance was, therefore, regarded by Freud as the most important part of the analytical technique. In trying to point out to the patient a certain form of his resistance, in isolating it from the normal part of his personality, and in translating its unconscious meaning, the analyst is able to study the different steps necessary to bring back repressed material. Sometimes analytic work appears to be short and dramatic, more often it is a slow and gradual process which may be compared to the growth of grass (or a tree).

The various forms of resistance\* may be illustrated by the following schematic presentation:

\*Obviously a similar approach may be used in the study of transference and counter transference.



From a phenomenological point of view, one may differentiate between the resistance which is expressed by a prolonged silence, and the resistance which makes the patient talk without interruption. Whenever this kind of talking takes place the analyst will have to prove to the patient (or to himself in case of counter transference) that silence is not caused by lack of material ("There is nothing in my mind," or "I told you everything I know."), but that it represents an attempt to make the analysis impossible. Some analysts are silent when they should talk; or they talk when they should be silent, because, as a result of their counter transference they are afraid to give an interpretation, because they are afraid of the patient. Only after both patient and analyst have recognized that the patient's silence, or his uninterrupted talk, is not due to conscious reasons, will he be interested in searching for unconscious data.

From a systematic point of view, one may differentiate between conscious and unconscious resistance. In analysis, we are chiefly interested in making unconscious resistance conscious. A patient of the author's, who had been in analysis for over two years and who knew a lot about analytical terminology, surprised him one day by saying that he had no resistance to this treatment because he liked it. Only after a long discussion in which the writer finally succeeded in reminding him that in addition to a conscious resistance there is also an unconscious one, did he recognize that his statement represented an unconscious provocation. He wanted unconsciously to make the analyst believe that he was feeble-minded and, therefore, unsuitable for analytic treatment.

From a dynamic point of view, one must separate the repressed material from the repressing factor. A patient refused to describe her masturbation fantasies. In order to overcome this resistance, the writer had to show her that the refusal which appeared to represent her modesty was based on unconscious reasons. The analysis in this case disclosed that it was caused by her unconscious fear of being overwhelmed by sexual desires and forced to masturbate during her analytic session. Another patient who had a similar difficulty was unconsciously afraid that discussing his masturbation fantasy might lead to deprivation of this outlet. The former resistance chiefly served the repressing tendencies, the latter, the repressed wishes, of the patient.



From an economic point of view a separation of the aggressive and the sexual (negative and positive) forms of resistance appears to be advisable. A female patient who kept on describing how she would enjoy having sexual relations with the writer was finally able to understand that her desires were not aroused by the author's sex appeal but represented her resistance to the recognition of an unconscious aggressive wish—a wish to humiliate the writer by rejecting him if he had accepted her offer.

From a topographic point of view, one may try to find in each example of resistance the part which represents the id, the ego and the super-ego. A patient who kept on being late was finally able to give up this form of resistance after the following interpretations were accepted: Being late meant, from the point of view of the id, "I want to stay in bed and masturbate"; and from the point of view of the ego, "I want to decide when I will start my work." From the point of view of the super-ego, being late represented a punishment because of the loss of time.

In some cases it may be possible to see that *one* of the three interpretations has been specially important and decisive in eliminating the resistance of the patient. Whenever this takes place, one may infer that this quantity of the resistance is caused by the amount of libido located in one of the three parts of the total personality. While in many cases, such a quantitative evaluation may be impossible, and while some analysts refuse to tell the patient about the structure of the human mental apparatus, an omission of any *one* interpretation may interfere with the analytical treatment.\*

This writer has the impression that one may separate resistance to the content of a certain wish from resistance to recognition of a narcissistic mortification connected with it.

For instance a patient who kept accusing the writer of despising him and of forcing him to be analyzed had little resistance to recognizing that his accusations were an unconscious defense against the recognition that he could not control the scorn he had for the writer. His accusations, by giving the writer a power he did not

\*This writer is under the impression that in addition to the three libidinal types described by Freud a fourth one could be accepted. In this fourth type, the greatest amount of psychic energy is concentrated in the sense organs, and most decisions are dominated by the external world. Consequently, in addition to the three interpretations described above a fourth one could be added: "You have to wait, not I."



have, thus were a denial of his own lack of power over himself. However, his resistance increased before it was eliminated—this only after he had recognized that his accusations that the analyst hated him were also an unconscious wish to be loved by the analyst.

Another patient, however, who also accused the writer of hating him and of forcing him to come to be analyzed, developed a great resistance against accepting the interpretation that he accepted the analyst's "orders" to avoid admitting that he had to obey his aggressive desires. On the other hand, he showed less resistance against the recognition that his hostility represented a defense against his unconscious love.

Most analysts agree that resistance should be approached from the surface and that there is no point in giving an interpretation as long as the patient does not consider his behavior to be an expression of his resistance. If a certain interpretation appears to be correct, the opposite interpretation should then be incorrect. However, an interpretation may be incorrect at a certain stage of analysis, or in connection with a certain symptom, and make sense on a deeper level.

Sometimes lack of resistance may cover a resistance which a patient of the writer's aptly named "denial by acceptance." This patient would sometimes accept an interpretation even before the writer had finished the sentence interpreting it. The aim was to avoid a discussion leading to a possible understanding and assimilation of the suggestion.

Another patient had the habit of fighting the analyst energetically. For a long time his analysis made no progress because of prolonged discussions. One day when it was attempted to explain to him the difference between a "possible" and a "probable" defeat, he insisted that such a differentiation could only be understood by a scientist (which he wasn't). Attempts to show him that, in daily business deals, he separated offers with a "possible" profit from offers in which a profit was "probable" failed completely to impress him. His resistance was finally eliminated when it occurred to the writer that he was unconsciously making fun of him by making him believe that he could not think logically.

While it appears impossible to present a complete list of the various forms of transference and resistance it may be advisable to add three examples which illustrate that, not the *localization* of a symptom, but the content of the regressed wish, is decisive.



A patient who used as his form of resistance a kind of mumbling which made the understanding of what he said very difficult, gave this up when it became apparent that it represented the satisfaction and the frustration of his oral wishes and that the analyst represented his pre-Oedipal mother.

Another patient who used to stammer whenever the analysis became too unpleasant got over his stammer when its anal origin was discovered.

A third patient, a woman who used to lose her voice at certain stages of her treatment overcame her aphonia when her penis envy—caused by certain traumatic experiences at the phallic stage of development—was brought into the open.

Transference, as it has already been said, represents the transfer of infantile emotions to the analyst, as a result of which the analyst becomes the person responsible for the traumatic events of the patient's childhood. According to the needs of the patient, the analyst may represent father, mother, brother or sister and may change the role he plays during the treatment.

Most analysts agree that it is impossible to analyze a patient who is unable to produce transference. However, while Freud originally had the impression that only a positive transference could be helpful, he later recognized that one could also analyze patients who had negative transferences and that a positive transference could sometimes become a resistance. While ability to deal with the various forms of resistance and transference has increased, it is still impossible to work with a patient who refuses to co-operate in a critical examination of these two phenomena. While it seems impossible to analyze a patient who is unable to produce transference, it is equally impossible to obtain unconscious material without analyzing resistance.

Transference seems to be caused by the patient's needs to discharge his infantile wishes and his interest in finding objects suitable for this discharge.\*

The analyst is a suitable object because he is ready, during his work with his patients, to forget about his own problems and to concentrate completely on the patients. Whenever the patient tries to discuss, in his analysis, the personal problems of the analyst, the analyst will try to show to the patient that what matters is

\*People free of repressed infantile wishes may, therefore, be unable to be analyzed.



not what the analyst feels but what causes the patient to speculate about these feelings.

This rule, like other rules, should not be taken literally. A short answer may sometimes be justified and a dogmatic insistence on analyzing each question of the patient may arouse unnecessary hostility. In dealing with transference and resistance the analyst needs common sense, tact and patience, in addition to his interest in the study of the unconscious.

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## COMMENTS ON SOME ASPECTS OF THE CURRENT (1953) RESEARCH PROGRAM OF THE NEW YORK STATE PSYCHIATRIC INSTITUTE\*

BY NOLAN D. C. LEWIS, M. D.

The aim of research at the New York State Psychiatric Institute is the maintenance of a program of investigation into the problem of mental disorder in terms of the total functioning of the individual. It is obvious that such a program transcends any single scientific discipline or method, and that it must include the efforts of many competent specialized workers. It is psychobiological in the broadest sense of the term, and the following account includes only a few of the procedures and investigations that are currently under way and actively productive. Its object is to present some samples and types of studies in the basic sciences that are of particular importance in modern psychiatric research.

To begin with the division of experimental psychiatry, there are different psychosurgical procedures under investigation including topectomy, medial lobotomy, precoronal lobotomy, and temporal lobe operations, in an attempt to establish the value of these operations. It has been found that the small or limited operations are sufficient for the improvement of many well-preserved schizophrenic and chronic psychoneurotic patients. The psychosurgical results are far superior, with practically all the operations used, in chronic neurotic and pseudoneurotic schizophrenic patients, than in the chronic and especially deteriorated schizophrenic patients.

During operation, electrical stimulation of the cortex is performed to ascertain what electro-encephalographic changes occur under the influence of such stimulation; and the mental behavior is also studied during this stimulation. These patients are operated on under local anesthesia. Investigations disclose that some psychophysiological functions may, perhaps, be localized in certain parts of the frontal lobe. Higher emotional and intellectual functioning, however, cannot be localized in specific parts of the frontal lobe.

Investigations with ultrasound techniques have been started. Apparatus has been constructed which is able to penetrate the brain to produce circumscribed lesions in it. This work will have

\*This paper was delivered at the bimonthly conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, New York, N. Y., March 11, 1953.



to be experimented with further on animals before it can be used on humans. The advantage of this method would be to produce lesions in the brain through the unopened skull.

The department is engaged in extensive investigations on experimental psychoses. Mescaline, lysergic acid, and a number of other compounds are used for this purpose. The search is actually for a model of how these substances produce psychoses, which would necessitate the knowledge of how certain drugs are absorbed and act on the nervous system, and of how they are eliminated. It is hoped that the influence of these compounds on the metabolism of the nervous system can be clarified to allow the psychotic manifestations produced to be better understood. As the mental changes produced by these drugs are strikingly similar to those seen in schizophrenia, it is possible that they will yield some insight into the pathogenetic mechanisms of that psychosis. Psychodynamic studies in patients under drugs indicate the great importance of anxiety and tension, seemingly at the root of many complex mechanisms such as aggression, depression and paranoid behavior.

It was found that sodium amytal and pervitin, mixed, act as an antidote against psychotic manifestations produced by mescaline and lysergic acid and probably even have a preventive value. Patients who receive sodium amytal and pervitin prior to administration of mescaline do not develop psychotic manifestations during the period they are under the influence of amytal and pervitin. Mescaline and lysergic acid were found to produce psychoses in "normal" individuals, in schizophrenics and in latent schizophrenics. They magnify and underscore the already existing symptomatology and are able to precipitate gross psychotic reactions in individuals with mild and subtle symptomatology.

Carbon dioxide treatment was investigated in a number of patients. It was found that it can be used as an auxiliary to psychotherapy similarly to such other procedures as sodium amytal and ether, but that it is not the specific organic treatment that has been claimed. It is fairly certain that its therapeutic efficacy is rather limited.

The department of experimental psychiatry is engaged in bringing together all the material on pseudoneurotic schizophrenics. This will be published as a monograph. Besides the clinical and theoretical concepts, it will also include a follow-up study on the outcome of the disorder in pseudoneurotic patients and an evalua-



tion of therapy. To some extent, psychotherapy is effective in these cases. Most impressive in the severe ones, are the results with psychosurgery (small operations) which relieve many of these patients of their crippling symptoms. Shock therapy (insulin and electric shock) has very little effect on this form of schizophrenia.

The current research activities of the department of medical genetics proceed along four concentric lines of approach toward the exploration of basic biological variations in the ability to maintain a state of physical and mental health under varying conditions of stress. The four projects are organized as (1) longitudinal twin sibship studies concerned with the genetic aspects of pre-adolescent schizophrenia, (2) familial forms of mental deficiency, (3) variable resistance to tuberculous infection, and (4) adjustment and survival in the period of old age. The first two projects are recent additions to the research program, the objectives of which were the topic of the 1952 series of the Salmon Memorial Lectures, and they are conducted in part in co-operation with the Bureau of Environmental Studies of the United States Public Health Service.

In the study of pre-adolescent or childhood schizophrenia, the emphasis is on the procurement of comparative family data, which are expected to throw some light on one of the haziest sectors of modern psychiatry. The main question here is whether, and under which particular circumstances, a true schizophrenic process may manifest itself at a very early age, and then predominantly in boys, although the maturation period of the female precedes that of the male. For the statistical analysis of this problem, it will be necessary to investigate whether the usual sex ratio prevails among the children of parents whose offspring include a person distinguished by a genetically-determined vulnerability to certain forms of mental disorder. If the sex ratio proves to vary from one group of family units to another—and there are some indications of such a trend—an entirely new approach will be open to research in the biological phenomena of human personality development.

Two topics have occupied most of the activity of the department of research psychology during the past year. These are (1) the development of several simple psychosensory and psychomotor tests as indicators of the efficiency or lack of efficiency of the central nervous system, and (2) the organization of a project dealing with the psychological prognosis in early and chronic schizophrenic



patients. The first of these problems has been facilitated by grants from the Carnegie Corporation of New York and the Rockefeller Foundation while the second is operating under a five-year grant from the United States Public Health Service.

The general idea that simple tasks might reflect the efficiency of the nervous system has a long and honorable history. The method was initiated in the psychiatric world by Kraepelin who sponsored a long series of such investigations. The mental examination which forms part of most psychiatric case histories contains many such items: Add or subtract serial sevens, repeat digits forward and backward, recount a story, etc. These tests were never too well-standardized and today are used only for suggestive purposes.

The development of newer technical methods, particularly those depending on electronic equipment make it possible to measure and record today with an accuracy far beyond that available a half-century ago. The development of statistical methods which can be applied to the performance of each individual in place of the analysis of data obtained from groups of patients also opens new possibilities. Lastly the concept of testing the reactivity of a single patient to mild transient physiological stress induced by chemical agents, anoxia or exercise, opens up new avenues of approach.

The work on these simple tests has been limited, so far, to reaction time, attention time, speed of tapping, finger dexterity, the critical threshold for flicker-fusion and high tone auditory thresholds. The work is all in progress. Much preliminary investigation has been completed. Several models of test equipment have been made and are being used. The schematic diagrams of the next series of special apparatus have been devised. During the course of several years to come it is believed that equipment, methods and standards will become available for everyday clinical use.

The purpose of the second project is to undertake a biometric analysis of early and chronic mental patients with the view of relating the measurements to their status at the end of a five-year follow-up. The following areas of behavior are to be sampled: (1) sensory, (2) perceptual and (3) conceptual. As a result of previous experience with patients undergoing psychosurgery the opinion has been formed that chronic patients who are poorer in their conceptual than in their perceptual abilities are likely to improve,



while those who are better in their conceptual than in their perceptual abilities are likely to remain in the hospital. In early schizophrenia, those patients who are but little affected in these capacities tend to improve, while those who show considerable lowering in their capacities tend not to improve.

In order to follow through the implications of this observation, four types of patients are investigated: (1) patients applying for psychoanalytic treatment who are considered unsuitable for psychoanalysis because of latent psychosis, (2) admissions to the Psychiatric Institute, (3) admissions to a state hospital, and (4) chronic mental patients who have been ill for approximately two years. It is believed that the results of this study will provide prognostic base lines for the probable outcome of mental illness.

In the department of bacteriology, the application of discs containing aluminum hydroxide cream to the cerebral sensori-motor cortex of *Macaca mulatta* monkeys has proved an effective method for the production of chronic epilepsy. Previous studies in this department have indicated that section of the corpus callosum, or contralateral pre-central motor cortical ablation, increased the convulsive response to aluminum hydroxide cream placed on one cortex. Consequently the workers are now engaged in evaluating the effect of ligation of contralateral cerebral arteries.

The middle cerebral or the anterior cerebral artery will be ligated intracranially near its origin from the circle of Willis. For each ligation groups of animals will be operated upon (1) before, (2) simultaneously with, the application of aluminum hydroxide cream, and (3) after the onset of seizures. Clinical examinations, serial EEG tracings, and motion pictures will be made at intervals, as well as neuropathologic studies at autopsy.

Since previous work in this laboratory suggested the existence in the pre-central motor cortex of the monkey of inhibitory fibers or mechanisms whose interruption at the cortical or callosal level facilitates convulsive reactivity, it is believed that functional interference with masses of contralateral cerebral hemisphere tissue may lead to an increased convulsive response. The results may indicate the role of impaired blood supply to the contralateral hemisphere in epilepsy, especially epilepsy of focal cortical origin. This has special interest because of the high clinical incidence of (a) epilepsy and (b) cerebrovascular accidents. It is believed that the data obtained on the influence of contralateral structures upon



focal cortical epilepsy will be of importance in evaluating the pathophysiology of epilepsy.

The department of neuropathology is presently engaged in two major investigations: (1) the production and prevention of experimental allergic encephalomyelitis in laboratory animals and (2) the evaluation of cerebral structural and histometabolic changes in schizophrenia.

The experimental allergic encephalomyelitis carried on in the department of neuropathology dates back to 1938 and was related to confirmation and further elaboration of the work of Rivers and Schwentker on the production of encephalomyelitis following intramuscular injections of brain suspensions. Subsequently with Freund's modified technique, the encephalomyelitic process, which took several months to a year to be induced with the Rivers method, could be precipitated with this new procedure within a few weeks. In attempts to detect the allergen responsible for experimental allergic encephalomyelitis, extracts of brain proteins, lipids and brain proteolipids have been found capable of producing encephalomyelitis. A basic contribution from the department on the pathology of human demyelinating diseases viewed as an allergic reaction of the brain established, apparently, the analogy between the pathologic processes of human demyelinating diseases and the pathologic processes of experimental allergic encephalomyelitis. While new avenues of exploration for the production of experimental allergic encephalomyelitis are in progress, the investigators are also interested in the prevention of this disease. Several approaches were used such as intramuscular and intravenous injections in the experimental animals of normal brain tissue, various dilutions of proteolipids, and hyaluronidase with the purpose of modifying the colloidal status of the antibodies, thus lessening pathological effect.

Additional biopsy from topectomies and postmortem material is being investigated in relation to the evaluation of cerebral histopathologic changes in cases of schizophrenia. From the study of a large number of cases one is impressed with the fact that, in the presence of cerebral structural changes in cases of a schizophrenic syndrome, one must evaluate first the following possibilities before reaching the conclusion advanced by some investigators that schizophrenia is an organic brain disease: (a) The morphologic changes may be the expression of complicating organic or bio-



chemical processes which may have developed during the course of the life of the patient after the onset of the schizophrenic symptoms; (b) the morphologic changes may be due to a primary organic brain disease which may have precipitated a schizophrenic syndrome; and (c) the morphologic and histometabolic changes may be the expression of a psychosomatic integration which results from the reciprocal interdependence of soma and psyche.

The department of pharmacology has continued its research program relating to amino acid and peptide metabolism in the central nervous system with particular attention to the metabolism of glutamine and glutamic acid.

The enzyme, glutamotransferase, which was discovered some years ago in this laboratory and which is assumed to play a role in the initiation of peptide and protein synthesis, has been highly purified, with brain as source material. The requirements of the enzyme for full activity were studied. It was found that it needs adenosine triphosphate in minimal amounts. These amounts are so small that a new role as a co-enzyme is suggested for adenosine triphosphate, which has, up to now, been assumed to act mainly as a source of biological energy. In the present studies, much emphasis is put on this point, since it is hoped that if the mechanism of this activation is understood, it will clarify, not only the mechanism of the action of this enzyme, but will also form a bridge between peptide synthesis and nucleic acid metabolism.

The formation of this enzyme has been studied during embryonic development. This plan of approach is pursued because it is felt that abnormalities of mental function in adult life may relate to enzymatic disbalance occurring during the embryonic development of the central nervous system. A preliminary study of glutamotransferase in the developing brain of the chick embryo has been completed. It could be shown that although the enzymatic pattern starts much later in the brain than in the liver, the concentration of enzyme at hatching is as high in the brain as it is in the liver.

A detailed study of the enzymatic conversions of the tripeptide, glutathione, is being carried out. It has been found that there exist enzymes in brain which transfer the glutamic acid moiety of the tripeptide glutathione to other amino acids whereby glutamic acid peptides are formed. A hypothesis regarding the role of these



mechanisms in peptide and protein synthesis has been outlined. In the framework of this hypothesis the enzyme systems in the central nervous system responsible for the synthesis of glutamine and glutamic acid are under close scrutiny. One of the goals of this research program is the development of understanding of amino acid and peptide metabolism of the central nervous system, to a degree which will make possible the preparation of drugs which may influence the abnormal metabolism of nitrogenous compounds. A number of such preparations have been, and are being, developed in the laboratory, and they will be put to test in the near future.

The department of biochemistry is engaged in an investigation of brain metabolism based on the procedure of Geiger and Magnes for the perfusion of the brain in the living cat. With this technique, a wide variety of experimental procedures may be applied. For example, substances may be added to the perfusion blood and circulated through the brain, the composition of the perfusion blood may be modified, and the brain may be stimulated electrically, or by drugs such as metrazol. The effects of such procedures may be measured by physical methods, such as the electrocorticogram and the response of the animal to physical stimuli, and by chemical analyses of inflowing and outflowing perfusion blood, of small biopsy samples of brain tissue, and of part or all of the brain at the end of perfusion.

Of the several studies to which the procedure has been applied, there is space to mention only one, as an example. One of the fatty acids, octanoic acid, labeled with radiocarbon, was perfused through the brain for a period of about five minutes. After the labeled substance had been washed out of the blood vessels, the brain was removed, and the lipids were extracted and fractionated. The radioactive  $C_{14}$  label was found in all of the lipids except cholesterol. Even purified cerebrosides contained small, but highly significant, amounts of  $C_{14}$ . One small fraction with the solubility characteristics of triglycerides (ordinary fat) was highly active. Attempts are now in progress to separate and identify the active constituents of this fraction by means of the countercurrent distribution method. These findings show that octanoic acid can penetrate into the brain; they indicate, contrary to current teaching, that there is a considerable metabolism of lipids in the brain; and



they open up the possibility of determining the pathways through which lipids are synthesized and broken down in the brain.

There are a number of clinical psychiatric researches under way that are interesting and promising. They will be reported in detail on another occasion.

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# FRUSTRATION-AGGRESSION HYPOTHESIS EXTENDED TO SOCIO-RACIAL AREAS: COMPARISON OF NEGRO AND WHITE CHILDREN'S H-T-P'S\*

BY EMANUEL F. HAMMER, Ph.D.

The concept of frustration and the problem of emotional reactions to it have recently come in for a large share of scientific attention. This is so not only in the cases of experimental and clinical psychologists, psychiatrists, and psychiatric social workers, but also in those of sociologists, social psychologists and educators. The volume, *Frustration and Aggression*, written by the Yale group,<sup>1</sup> which may well become a classic, has most clearly focused attention on this problem.

It is commonly accepted that frustration consists of the thwarting or blocking of an individual's significant drives, motives, or needs. Symonds,<sup>2</sup> for example, defines frustration as "the blocking or interference of the satisfaction of an aroused need through some barrier or obstruction." Maslow,<sup>3</sup> however, holds that frustration consists of two aspects: deprivation and personality threat. Deprivation of an ice cream cone for a child, for example, does not necessarily constitute frustration, but when such deprivation is viewed by the individual as representing rejection by the mother who denies the ice cream cone, it constitutes a frustration. Similarly, whereas economic discrimination against the Negro may or may not represent rejection, social discrimination against him must, almost by definition in our culture, represent rejection and, hence, eventuate in frustration.

For the child of Negro race, the outer white world is often found to be full of disappointment, frustration, and threat, both covert and overt. In addition, such a child feels the reflected differences in opportunity and the comparatively meager advantages that are presented to his parents in our present-day American society, as opposed to the greater opportunities and advantages presented to the parents of his white contemporaries.

\*From Research Project, New York State Psychiatric Institute. Grateful acknowledgment is made to John N. Buck, for serving as technical and editorial consultant, and to Miss Hannah S. Davis and Mrs. Lila K. Hammer, who, in addition to the writer, served as clinician-judges for the H-T-P's. Further thanks are due Allen Cohen, William Dakos, and Miss Lois Brinkman for serving as supplementary clinician-judges.



A comparison, then, between the relative degrees of aggression in Negro and white children appears to offer fertile research grounds for the extension of the frustration-aggression hypothesis to social and racial areas.

An investigation of this type would appear to have significance also for concepts of psychodynamics relative to the Negro and white groups. Hadley<sup>4</sup> points out that certain approaches to psychotherapy fail to take into sufficient account objective social conflicts as causes of personal conflict. Therefore, the frustration-aggression hypothesis would appear to deserve very careful consideration in evaluating the adjustment level of a Negro patient or subject. Many psychotherapists believe that hostility and aggression assume a decisive role in the difficulties in living for which individuals seek psychotherapy. Fenichel<sup>5</sup> gives much consideration to the varied manifestations of forbidden aggression and hostility as expressed in emotional problems, and Horney<sup>6</sup> espouses the view that aggressive impulses of various kinds form the main source from which neurotic anxiety stems. The etiological importance in schizophrenia of guilt-producing hostility and destructive urges is well known and has received due emphasis from Fromm-Reichmann<sup>7</sup> and the Sullivan group.

The idea of using a projective technique to tap the intensity of hostility in the subjects of the present study grew from a recent study of Bellak<sup>8</sup> which deserves mention in this regard. Ten TAT cards were divided into two groups of five cards each. Subjects made up themes for the first set of five cards and were, thereupon, sharply criticized for the poorness of their stories. Then the remaining five cards were administered with the subject criticized after each of these cards. Analysis of the stories by three judges indicated that the amount of aggression and hostility increased very significantly following frustration. This study suggests the appropriateness of studying the variable of aggression-hostility by the use of projective techniques.

#### PROCEDURE

The free-hand drawing of House, Tree and Person was used to tap the personality of the Negro and white children in the present study because it represents a quick and easy-to-administer projective technique which seems to be penalized less by group administration than most other projective devices. H-T-P's had been



administered to 148 Negro children\* from grades one to eight in a gratifyingly representative (from a socio-economic viewpoint) semi-urban, semi-rural school in Virginia during a previous study.<sup>9</sup> As it was not feasible to attempt to equate a white control group on the same socio-economic level, since relatively few Negroes in Virginia are of a socio-economic level comparable to the majority of the whites, the students of the companion white school in the same community were tested. Group H-T-P's were administered to 252 white children ranging from grades one to eight. Thus, data were elicited with the aim of comparing the two groups as they tend to function in their respective cultural settings.

The 400 H-T-P's were put into random order of Negroes and whites by grade level. The clinician-judges, without knowing whether they were rating drawings made by Negro or white subjects, rated each H-T-P on a scale of aggression from zero to two. A rating of zero represented no apparent aggression or hostility, a rating of one represented mild aggression or hostility, while a rating of two represented severe aggression and hostility. Three clinicians served as judges for the drawings of all eight grades of the Negro and white children, while three additional clinicians served as judges for the third, fifth, and seventh grades in order to afford the opportunities for a spot check.

Correlations of the judgments of the three principal judges were then computed. All six judges, principal and secondary, were put in rank order according to the degrees of hostility they apperceived in the 400 H-T-P's they had rated. This rank order was then compared with the rank order in which the judges were rated for hostility by the writer, who was supervisor of intern training at Lynchburg (Va.) State Colony, which was conducting the study. The supervisor rated the clinicians on the basis of the degrees of aggression and hostility manifested by the clinicians in their interaction with patients and other staff members. The clinicians were placed in rank order of hostility before they judged the 400 drawings; and they did not know of the dual end to which their ratings would be put until after their data were handed in and their consent obtained.

The drawings were rated on the basis of the following qualitative signs for aggression and hostility from the *Guide for Qualitative Research with the H-T-P*:<sup>10</sup>

\*By John N. Buck, Miss Patricia Nigg, Mrs. Audrey Mailer and Bernard Meiselman.



The drawing of attic windows which are open implies hostile phantasy which causes the person guilt. It has been observed that subjects who are extremely prone to phantasy in hostile fashion frequently provide themselves with what might be called "safety valves" by drawing open windows in the area symbolizing phantasy thinking, the roof.

Windows drawn without panes, curtains or shutters (hence, like the "key-hole" Tree below, another depiction of unrelieved, enclosed, white space) may imply hostility.

A Tree which consists of a looping line representing the Tree's branch structure (unclosed at its junction with the trunk), and two vertical lines closed or unclosed at the trunk's base (thus resembling a key-hole) is taken to indicate strong hostile impulses.

Two-dimensional branches that are drawn resembling clubs or sharply pointed branches or leaves, especially with little organization, imply strong hostility.

A mutilated Person or a degraded Tree or House, it goes without saying, serves to underscore the patient's hostility. The use of degrading details which serve to symbolize feelings of aggressive hostility may include such depiction as an out-house drawn beside a House that is otherwise a mansion, a large conspicuous garbage can drawn on the front porch, or a dog drawn as urinating against the trunk of the Tree.

Sharply pointed fingers and toes, as well as other similarly treated details, are a reflection of aggressive tendencies, as are teeth prominently presented in the drawing of the face.

Sharply squared shoulders in the drawing of the Person connote over-defensive, hostile attitudes.

Well-outlined, but unshaded hair, in the drawing of the Person suggests hostile phantasy concerning sexual matters.

Arms that are drawn folded across the chest suggest attitudes of suspicion and hostility.

The Person carrying weapons such as guns, black-jacks, etc., clearly indicates aggressive and hostile tendencies.

The Person presented in a threatening attitude (example, fist upraised, etc.) bespeaks aggressive hostility.

Drawings made conspicuously too large for the page, without adequate page space framing them (particularly when they touch or almost touch the page's side margins), tend to indicate a feeling of great frustration produced by a restraining environment, with concomitant feelings of hostility and a desire to react aggressively, either against the environment, the self, or both.

The least objective approach at this stage of the H-T-P's development, Buck<sup>11</sup> writes, is that of interpretations made on the basis of qualitative indications. It is also the most dependent for



its skillful and successful usage upon the experience and capability of the clinician, but it is often by far the most revealing.

The qualitative points listed here were employed as broad guideposts in an effort to increase, in some measure, the objectivity of the qualitative approach employed in the present study. The greater the number of "signs" of hostility and aggression in a set of drawings, the more inclined the clinicians were to go up the continuum from mild to severe in their ratings. Since the dynamic interrelationship of a sign with all other signs available is of prime importance, however, each drawing was viewed as a gestalt. An attempt was made to take the total constellation into account at all times.

### RESULTS

As can be seen from Table 1, the mean aggression and hostility rating for all eight grades of white children is .308 which is approximately three-tenths of the distance up the continuum from a point of no apparent aggression and hostility to a point of mild aggression and hostility. The mean hostility rating merited by the drawings of the Negro children is .823, a point approximately eight-tenths of the distance up on the continuum between a point of no apparent aggression and hostility to a point of mild aggression and hostility. Hence, the white children prove to be closer to the point of no apparent aggression whereas the Negro children score closer to the point of mild aggression. A t-score of 12.56 is statistically significant at far better than the 1 per cent level of confidence and indicates that a real difference exists between the degree of need for aggression in the Negro and white groups, with the incidence being higher in the former.

No consistent trends, either absolute or relative, are apparent in the hostility index of the Negro and white children when broken down by grades. Whether a trend becomes apparent when the data are extended into the high school age group is currently being investigated by a follow-up study.

In perusing the drawings for indications suggestive of aggression, the clinicians became aware of a striking incidence of drawings made conspicuously too large for the page, without adequate space framing them. Buck<sup>11, 12</sup> writes that drawings made conspicuously too large for the page, without adequate space framing them, tend to indicate a feeling of great frustration produced by a



Table 1. Comparison of Average Hostility Indices of Negro and White Children by Grade Level\*

Grades	White	Negro
1 .....	0.19	0.84
2 .....	0.19	0.88
3 .....	0.38	0.75
4 .....	0.17	0.82
5 .....	0.27	0.81
6 .....	0.44	1.18
7 .....	0.47	0.58
8 .....	0.36	0.73
Mean .....	0.308	0.823

\*A rating of zero represents no apparent aggression and hostility, one represents mild and two represents severe aggression and hostility.

restraining environment with concomitant feelings of hostility and a desire to react aggressively. When the incidence of such drawings was tabulated quantitatively it was found that 10.3 per cent of the white children presented such drawings whereas 28.3 per cent of the Negro children did so. A t-score of 3.84 indicates a statistically significant difference at the 1 per cent level of confidence in regard to this factor. Hence, this quantitative tabulation supports the qualitative judgments of the clinicians that the Negro subjects harbor greater feelings of frustration, with a desire to react aggressively, than do the white.

The correlation between the judgments of clinician X and clinician Y is .84 with a standard error of .014 and a probable error of .009. Correlation between the judgments of clinicians X and Z is .78 with a standard error of .030 and a probable error of .021. A correlation of .74 with a standard error of .031 and a probable error of .020 exists between the hostility judgments of clinicians Y and Z. Thus, correlations ranging between .74 and .84 are found among the three main clinician-judges.

All six clinicians, the three main and the three secondary judges, were placed in rank order in regard to the degree of hostility they manifested in interpersonal relationships as judged by the supervisor. A comparison of this rank order with the rank order of the degree of hostility they saw in the H-T-P drawings of the 400 subjects is presented in Table 2.



Table 2. Comparison of Rank Order of the Average Hostility Indices Given the 400 Drawings by Each of Six Clinicians and the Rank Order of the Degree of Hostility in Each Clinician as Judged by Their Supervisor\*

Clinician-judge	Average hostility index awarded the drawings	Rank order** of hostility index awarded the drawings	Rank order** of supervisor's rating	Difference in rank order
A .....	0.49	1	1	0
B .....	0.51	2	3	1
C .....	0.57	3	2	1
D .....	0.63	4	4	0
E .....	0.90	5	5	0
F .....	1.12	6	6	0

\*A rating of zero represents no apparent aggression and hostility, 1 represents mild and 2 represents severe aggression and hostility.

\*\*In ascending order.

It can be seen that the supervisor's ranking and the ranking on the basis of the degree of aggression and hostility interpreted from the children's drawings agree perfectly in regard to clinician-judges A, D, E, and F. A reversal is found in regard to clinicians B and C where the supervisor rated clinician B as second and clinician C as third in ascending order of aggression and hostility; on the basis of the degree of aggression and hostility seen in the drawings, clinician B was third and clinician C was second. A rank order correlation of .94 with a standard error of .48 and a probable error of .32 is obtained.

## DISCUSSION

If we take as an assumption the view that the Negro child suffers more frustration than the white child, as defined by its criteria of deprivation and personality threat, the frustration-aggression hypothesis when extended to social-racial areas receives support from the present study. This is in accord with a study by Bender<sup>13</sup> in which she found a proportionately greater incidence of childhood behavior disorders in Negroes than in whites. Since aggressive and hostile impulses which tend to be acted out are an important criterion for the diagnosis of childhood behavior disorder, this study and Bender's appear to be complementary. St. Clair,<sup>14</sup> on the basis of extensive psychotherapy experiences with Negroes, writes that hostility is a dominant problem for them and



should receive particular attention during therapy. These studies tend to support the view that racial prejudices and inequalities—oftentimes providing life-long and inescapable frustration—tend to produce aggression as a reaction.

An interesting psychoanalytic view of the Negro's supremacy in athletic competition with whites is congruent with the findings of the present study and suggests a sublimation of some of the aggressive impulses by the Negro who often dares not express them directly. Holloman<sup>15</sup> holds that the motivation for the Negro's drive for supremacy in this area is hatred and a desire for revenge, as well as efforts to compensate for feelings of inferiority.

From a pragmatic point of view it would appear that aggression would be elicited as a reaction on the part of the Negro as long as a caste system exists, whether overt or as a subtle undercurrent, in which he is afforded less opportunity for democratic participation in society than his white contemporaries, and is further handicapped and frustrated in the competitive struggle for achievement and status.

To turn to the question of the correlation of the judgments made by the three main judges, correlations ranging between .74 and .84 suggest a reasonably high degree of reliability among clinicians rating a qualitative factor such as aggression on the basis of the H-T-P. In spite of these reassuringly high correlations, however, it appears that much subjectivity enters into and distorts the interpretation of a factor such as hostility in projective drawings. The supervisor's judgment of the degree of the clinicians' hostility and aggression, as manifested in their interrelationship with patients and staff members, was found to correlate to a marked degree with the proneness of the clinician to see hostility in the drawings of other subjects. This finding may be partly explained by the differences in *sensitivity* on the part of the various clinicians to the particular personality factor, aggression. In addition, the differences among the clinicians' interpretations on the basis of the projective technique are probably further due to the fact that, when interpreting a projective technique, clinicians tend to *project* as well as interpret. This appears to be supported by both (1) the high correlation between the writer's ratings of hostility in the clinicians and the degree to which they saw hostility in the 400 H-T-P's they interpreted; and (2) the fact that clinician F, for instance, awarded the drawings an average hostility index which ap-



proaches the point of being twice the mean hostility index awarded by the other five judges.

#### SUMMARY AND CONCLUSIONS

Four hundred H-T-P's were administered to Negro and white children ranging in grade level from first to eighth. The drawings were put into random order of Negroes and whites by grade level. Six clinicians, without knowing whether they were rating drawings by Negro or white subjects, rated each set of drawings on a scale of aggression consisting of three points: none, mild and severe. The six judges were put into rank order on the basis of the degree of hostility and aggression they apperceived in the 400 H-T-P's rated. This rank order was then compared with the rank order in which the judges were rated for hostility by the supervisor on the basis of his observation of their interaction with patients and staff members.

Since the results of the study were obtained from students in two schools of one community, the validity of the results should be tested on other pairs of comparable groups. However, the following tentative conclusions (the further validity of which can be established only by studies in other geographic areas) seem justified.

1. The mean aggression and hostility rating earned by the drawings of the white group of school children is significantly lower than that of the Negro children. The drawings of the Negro children suggest greater feelings of frustration produced by a restraining environment, with concomitant feelings of hostility and a desire to react aggressively.\*

2. If the assumption is accepted that the Negro child suffers more frustration than the white child, as defined by its elements of deprivation and personality threat, then the frustration-aggression hypothesis, when extended to the social-racial area, is supported by the present study.

3. There is a reasonably high degree of reliability among the clinicians who served as judges in the present investigation in their ability to judge the degree of aggression and hostility as manifested in a subject's free-hand drawing of a House-Tree-Person.

\*This aggressive potential may be directed outward against the environment, inward against the self, or both.



4. In spite of this relatively high degree of reliability, the clinicians' interpretations were, in part, determined by their own projections.

5. As suggested in a previous study,<sup>9</sup> the relatively greater incidence of aggression and hostility found in a "normal" sampling of Negro children suggests that the clinician must be cautious in interpreting the projective protocols of a Negro subject. In evaluating the severity of a record, two different and somewhat antithetical frames of reference invite equal consideration. It is necessary to keep in mind the concept of relativity in regard to other members of the same race, while simultaneously keeping faith with the concept of a baseline representing an optimum or ideal state of personality adjustment—regardless of how many others of the same race are similarly suffering from the particular neurotic symptom.

6. More extensive studies of comparable white and Negro populations, in different geographic areas, should be undertaken with particular emphasis upon analysis of the total personality.

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## PSYCHOTHERAPEUTIC APPROACH TO SCHIZOPHRENICS THROUGH INSULIN-COMA TREATMENT\*

BY DESIRÉ ANNAU, M. D.

It is almost generally agreed that Sakel's insulin-coma treatment is, at the present time, the best treatment available for schizophrenics. It gives the best results mainly in the paranoid form of schizophrenia, where other methods usually fail to give lasting improvement.

In spite of the recognized good results, its mechanism of action is still much debated and obscure. Sakel himself believes in a specific metabolic action that regulates the hypothetic metabolic disturbances of schizophrenics. He does not believe in additional psychotherapeutic action, and warns against any other types of shock treatment, considering them as harmful to the brain and nerve tissues. This conservative viewpoint and the specific action claimed are much contested by most other observers.

These other observers deny the superiority of the insulin-coma treatment *per se* and believe that the better results obtained with it are due to the accompanying intensive nursing care. These workers believe that the sympathy, effective help, and friendliness experienced during the treatment help the patients to regain their faith in other people's good will, disperse their resentment, assist them in giving up their isolation and offer them many occasions to overcome their shyness and fear of associating with other people. Experiments to clarify this point have been performed by placing two groups of patients under the same conditions of treatment and care. One group received insulin, the other sterile water injections. The result was that the patients receiving insulin showed the usual improvement rate, the others' conditions fluctuated as those of schizophrenics without treatment. This experiment demonstrated that the special care of the insulin patient is not the only curative factor, but did not prove that the insulin's metabolic action is the sole factor involved. The profound subjective sensations during insulin treatment are psychological factors which cannot be neglected. The increasing hunger and thirst, extreme sweating, overwhelming weakness and drowsiness, then the slow regaining of consciousness again are experiences which deeply affect the patient.

\*Read before the up-state interhospital conference, Syracuse, N. Y., April 16, 1952.



Others believe again that insulin-coma treatment is no more than one of the so-called shock treatments, the better results are only due to the longer duration of the treatment. The importance of the time factor cannot be disregarded. There is no other systematic psychiatric treatment that is commonly applied for such a long period. Only Klaesi's continuous-sleep treatment can be compared; this lasts for about 200 hours, as the insulin-coma treatment does, reckoning from the onset of the insulin reaction to the complete termination of the coma. The essential difference remains that the continuous sleep's duration is about eight to 10 days, whereas the insulin-coma treatment is given for about 60 days.

If one considers the clinical and psychological effects of the various shock treatments, they seem to indicate that each type of treatment sets a characteristic mechanism of its own into action. The prompt and quick relief of the electric convulsive treatment in all types of depressions is above discussion. The involutional and manic-depressive depressions usually disappear after a few treatments, although the results in reactive depressions, without simultaneous psychotherapy, are not so constant, and relapses often occur. In manic states the results are discouraging, unless several daily applications are used. Catatonic stupor is often not influenced by ECT, but quick relief is achieved with a few metrazol-convulsive treatments. The writer has seen quite a few cases where ECT has been without results, but where metrazol was followed by prompt disappearance of the catatonic symptoms. With the Emma modification,\* metrazol treatment lost its main contra-indication, the fear, terror and panic suffered by the patients. With the addition of 2 cc. of 50 per cent glucose solution, patients take the treatment easily without any apprehension.

Electronarcosis seems to have a specific beneficial action in anxiety states and marked tenseness. It gives prompt relief—better than any sedation. It is often very useful in anxiety neuroses when, because of severe anxiety, the patient is unable to co-operate in psychotherapy. After a few treatments, the patients are usually relaxed enough to enter productive psychotherapy.

Klaesi's, in the writer's opinion, unduly-neglected, continuous sleep treatment's clinical usefulness lies between metrazol and electronarcosis. It calms agitated patients and makes un-co-operative patients amenable to psychotherapy. In the writer's estimation,

\*Emma: Psychiatrisch, Neurologische Wochenschrift. 1940.



it is still the best treatment for psychogenic excitement, when "narcoanalysis" and synthesis remain without effect.

All the treatments mentioned seem to act mainly by relieving emotional pressure and liberating patients from overwhelming affective involvement. They make them able to face their problems in a sober and objective manner. Pathological ideation seems to be uninfluenced by these treatments. Involutional depressed patients with paranoid trends are relieved from their depressions, but their paranoid ideas remain unchanged. Often, only after ECT, when the depression is relieved, does the paranoid trend become visible. How deep-seated the emotional changes after treatment are at times has been shown in a letter received a short time ago from the husband of one of the writer's depressed, paranoid patients. This patient had had latent homosexual tendencies all her life, and had remained absolutely frigid during her 17 years of marriage. Before coming to Marcy (N. Y.) State Hospital, she was treated in a private sanatorium with ECT; her depression was relieved and, to the great surprise of her husband and herself, she was able to enjoy normal orgasm. After two or three weeks, however, she slowly relapsed into her depression and again became completely frigid.

It is not the object of this presentation to enter into deeper analysis of the emotional changes during and after convulsive treatments. The aim is only to show that we are far from knowing the mechanism of the beneficial action of these various treatments. Each seems to have its own peculiar action and indication. Clinically, they all seem to act by relieving emotional tension, but have no direct influence on the pathological ideation.

The writer has administered insulin-coma treatments, on a large scale, for about 15 years. At first, he paid no attention to the specific behavior of the patients and was more concerned about general condition, quality of the coma, and neurological and laboratory findings. As the writer had been used to the good rapport and abundant productions during the continuous sleep treatment, insulin-coma did not seem to him to offer any psychotherapeutical material, and the writer believed as Sakel and others still believe, that insulin acts on the metabolism and that its proper application is the sole therapeutic agent. It is true, that during this period, the writer spent only as much time with the patients as was necessary to terminate the comas and intervene in emergencies.



Later on, when the writer witnessed sudden transitory changes in patients' behavior during the postcomatose period, namely, hallucinations, bizarre mannerisms and agitation in otherwise well-composed and not hallucinating patients, or seemingly normal behavior in disturbed patients, he was with the patients during the whole course of the treatment and was rewarded by a wealth of important psychodynamic material.

To illustrate what this material is like and how it can be utilized, a few cases of observations at Marcy will be described briefly.

### *Case 1*

V. R., a 23-year-old woman, described as sensitive and shy but generally cheerful and active, had "gone steady" with one boyfriend for two years prior to her hospitalization, and for about a year had had sexual relations with him. The boyfriend had a, seemingly well-deserved, bad reputation which she disregarded. Her parents frequently warned her and were opposed to this friendship. She would not break with the boy but left her family, rented a room, and there received him undisturbed. They had frequent arguments, the boy missed dates, neglected her at times and showed interest in other girls. She became somewhat depressed and returned to her parents but continued to see the boy. One night after having had intercourse with him, she felt sick, on her return home called her mother, said that something was wrong in her insides, and that she had contracted syphilis. Since that time, she had been constantly afraid that someone was following her. She accused her parents of always interfering in her life, never allowing her to have fun, and of preventing her from marrying her boyfriend because of their different religions.

She received eight electric convulsive treatments in a private sanatorium and was considered recovered, but 10 days later she was admitted to Marcy where she was withdrawn, un-co-operative and actively hallucinated. She exhibited bizarre mannerisms, was emotionally dull, and stood or sat for hours on the same spot, uninterested in her surroundings. She denied there was any reason for her hospitalization and declared that she was brought to the hospital by her parents only to spite her and separate her from her boyfriend. She was soon placed under insulin-coma treatment, and often had spontaneous convulsive seizures, her condition remained



unchanged for a considerable period of time. Repeated interviews did not reveal any new material; she always emphasized her love for her boyfriend and her hate for her parents who wanted to destroy her happiness. She wrote letters daily to her boyfriend, but he never answered and never came to visit her. She explained his behavior by saying that her parents forbade him to have any communication with her.

She went down into coma quietly and came out without any restlessness or excitement. She had a vague smile at times, but said nothing. One day, near the end of the treatment, she came out of coma crying bitterly. As she never had had such an emotional reaction before, she was immediately interviewed and was asked why she was crying. Still sobbing she said that she knew her boyfriend went out with other girls and that that was the cause of their frequent arguments. The day she became sick, she felt sure that he had had intercourse with another girl, and that is why she feared she had contracted syphilis. During this and other interviews, she spoke freely about her doubts and grief over the love of this boy. She admitted that her parents were right when they objected to him, but she felt unable to give him up after she had "sacrificed everything" for him. After these interviews, her behavior changed completely. She became cheerful, mingled freely with other patients, became attached to some of them, cared more for her appearance, and showed much affection toward her parents.

### *Case 2*

E. A. T. is a 26-year-old teacher, separated from his wife. He had always been very closely attached to his mother. His social relations had been, for many years, exclusively with men. He did not go to dances and was shy with girls. He had been in the navy for two and one-half years, during which time he had his first sexual relations with girls. He characterized these girls as oversexed and himself as cold-natured and suffering from quick orgasms. After his honorable discharge from the navy, he finished college. He married a girl in 1950 whom he had known for several years. They never adjusted well to their marital status; he went to his mother daily and she to her parents. During the first weeks of marriage they were unable to carry out intercourse; she was a virgin and he was unable to pass the introitus. Later on they consummated their marriage, but both were dissatisfied. He always



had the uneasy feeling that somebody would surprise them during intercourse. This, he thought, was the cause of his too quick ejaculations. This marriage was annulled after one and a half years, but he claims that he still loves his wife "more than a sister."

Prior to marriage, he had felt tense, nervous, had some difficulty in concentrating and in making decisions and had always felt the need to discuss his problems with his mother. After marriage, these symptoms became more accentuated, and he himself admitted his inability to assume a masculine role. He enjoyed teaching children and was considered a very good teacher. When he was assigned to teach adults, he became afraid, quit his job immediately, and was so upset that he ran around with his car wanting to have an accident and kill himself; but, finally, not having enough courage to do so, he went home.

He was admitted to Syracuse Psychopathic Hospital where he showed catatonic features. He complained about the feeling that his head was split in halves. After a few electric convulsive treatments, he believed that his thinking was clearer and recalled a childhood experience when he was being chased by a little girl who wanted to "neck" with him, but he had protected himself by swinging a chain. In October 1951, he was admitted as a voluntary patient to Marcy. He was retarded, depressed, and perplexed. He repeated, over and over again, his sensations in minute detail, but was unable to give an over-all picture of his condition. There was considerable blocking and inhibition, associations were scattered and illogical. He wanted constant attention and interviews without being able to offer further material. He was soon placed under insulin-coma treatment. Before going into coma, he became fearful, but was calmed when someone was near his bed. When coming out of coma, he was restless, agitated for a while showing marked fear and anxiety, but soon relapsing to his former attitude and asking for interviews.

Once when he was told on such an occasion that he could not have an interview, he asked anxiously, "Does it mean that you will drop me as hopeless?" This patient, having a French name and speaking a little French, was approached sometimes in French. One day when coming out of coma he was greeted with "*Comment allez vous?*"\* to which he answered after a short hesitation, "*Voulez vous coucher avec moi?*"\* It was not a surprise to hear

\*"How are you?" and, "Would you like to go to bed with me?"



such an overt homosexual advance, as his history was suggestive of such tendencies. In former interviews, the writer had often tried to discuss homosexuality, but there had been no response—only intensive blocking. After this occurrence, the patient was directly questioned about homosexuality. He denied ever having had homosexual relations, but spontaneously admitted he had never been sure of his manliness. He was seemingly glad to discuss this topic and showed much understanding and interest, but never responded on a subjective level. Nevertheless, he apparently was much relieved when he was assured that homosexuality is not a fate but a faulty habit. There was marked improvement in his condition after these interviews, and his restlessness on coming out of coma slowly faded away.

### *Case 3*

K. G. R. is a 41-year-old divorced man, characteristically very accident prone during his whole life. There is a long history of a schizophrenic process; and he has been in and out of mental hospitals since 1939. He has been in Marcy State Hospital since 1949. He showed a mixture of catatonic and paranoid features: negativism, assaultiveness, grandiose ideas, ideas of reference, auditory and somatic hallucinations. During his previous hospitalization, he received ECT without any improvement; and he suffered a chipped fracture of a vertebral body. He was placed under insulin-coma treatment October 1951 as one of the chronic cases to be treated. At that time, he was more catatonic than paranoid, stiff, negativistic, refusing to co-operate and stating that his health depended on magnetism and that all his bones were broken. He would lie in bed with closed eyes, in a stiff position not moving for hours.

Before going into coma, he became restless, agitated, fighting with all his strength. When coming out of coma, he was friendly for a while, but soon relapsed to his former negativistic behavior. During the treatment, there was slow improvement insofar as he showed a little interest in his surroundings and became more co-operative for hospital routine. One day when coming out of coma, he was unusually restless, struggling with his feet in a state of acute anxiety, repeating imploringly, "Loosen my shoes, loosen my shoes!" He was in the usual chest and feet restraint. When his feet were freed, he smiled happily. As he had always been re-



strained in the same manner and had not complained previously, he was interviewed at once and gave the following story:

When a small boy, he had a pair of new shoes at Easter time. He had gone to church with his mother. The shoes were very tight and he "suffered terribly." He complained to his mother about this, but she would not listen and ordered him, scolding, to be quiet. He had agonizing pains until at last they arrived home. His feet were swollen and covered with blisters. His mother, who had been cross with him in church and on their way home, was very good to him when she saw his swollen feet. She put him to bed, gave him candy, and did everything to comfort him and to relieve his pain.

The day after telling this, his restlessness was less marked and he was surprisingly friendly and interested in other patients. He took part willingly in all activities. On another occasion, when he had a late reaction, he became very restless and excited. After giving him intravenous glucose solution, the writer spoke to him in a loud voice. He suddenly relaxed, smiled and said, "Are you here doctor? We could eat some spaghetti." When interviewed immediately and asked about the cause of his restlessness he said, "I thought I was in prison."

When questioned further about his fear of prison, he said that when he had had the pains in his feet, his mother threatened that, if he did not keep quiet, the police would take him to prison, and that later, at home, his mother gave him spaghetti. Since that time, he had always been afraid of being locked-in in a prison; and he does not believe that he deserves this. After this interview, his pre- and post-comatose anxiety disappeared gradually and his mental condition further improved.

In this connection, the writer would like to stress the fact that the anxiety and agitation had nothing to do with the restraint. In sanatorium practice, where patients usually are not restrained, and in late reactions, when patients are out of bed, one sees the same reactions. There are a number of patients who never show any anxiety or agitation.

#### *Case 4*

N. L. C. is a 29-year-old single man. The mother of this patient died in a mental hospital when the patient was very young. His father remarried and the patient was in a foster home for a long time. After school, he went to the CCC and shortly afterward, in



1940, he joined the army, receiving an honorable discharge in 1948. During his army service, he drank heavily and was hospitalized for the first time in a mental hospital with the diagnosis: inadequate personality, chronic alcoholism. Three more hospitalizations followed, and finally he was admitted to Marcy State Hospital in November 1950.

He was described as having a lot of self-confidence, "pep," being a hard worker, good-natured, having a winsome personality, and being a "little lamb when sober." When drunk, he threatened everyone who was near him. He was in numerous fights during his army service and afterward. At times, he had some kind of fainting spells with subsequent amnesia. He had a very active and promiscuous heterosexual life and a few homosexual relations.

During his previous hospitalizations, there were periods of hallucinations with vague ideas of reference and persecution. Prior to his admission to Marcy, he had a period of tenseness, depression and suspiciousness, complaining that people were talking about him, referring to his homosexual relations. One night, in a state of fear he went to the police station, and asked to be allowed to sleep there. During the night, he became extremely excited, screamed and shouted that there were people who wanted to shoot him, and that his father was hiding with a gun. From there, he was brought to the hospital. On admission, he showed the picture of acute catatonic excitement with auditory and somatic hallucinations, and a panicky state of fear of immediate death. After a few days, he became withdrawn and seclusive, and stared at the ceiling, motionless for hours. When asked what he was doing, he said that he was talking to God and that the Lord told him to call a priest. Later, he declared that he himself was God.

He was soon placed under insulin-coma treatment. During the pre- and post-comatose states, he was extremely agitated, as if fighting for his life. When out of coma, he was asked about the cause of his fears and he invariably said, "I must have had a bad dream." This extreme agitation recurred every treatment day until one day he had a late reaction. The writer was called and arrived just before the onset of the coma. He was still able to respond but was extremely restless. A small amount of sugar solution was given to keep him awake and he was immediately interviewed. He told the following story:



Every time he felt the weakening action of insulin a terrifying experience came into his mind. His mother was "taken away" when he was about two years old, and he was placed in a foster home until he was six. When he came home, he stole a dollar from his older brother and was soon caught. His brother took him down to the cellar, tied him down and let him lie there for three days without food or drink. Since that time, he has always feared being strangled.

An adequate amount of sugar was given, and this experience was thoroughly discussed. During the following treatments, there was only moderate restlessness, which slowly faded away completely. His condition improved slowly prior to this interview, but afterward the treatment could soon be terminated. After many months, this patient is still in fairly good condition.

\* \* \*

These sketchy case histories are intended only to serve the purpose of giving a general idea of individual cases and to show the material offered during the pre- and post-comatose states. The interviews are merely mentioned without entering into details of further material revealed. Interpretations were given to the patients only with the material spontaneously offered and usually using their own words.

Considering the cases described, one sees that in two instances the patients remembered, or—to put it more cautiously—spoke about, only during the pre- and post-comatose clouded states, important childhood experiences they never mentioned before. In a third case, the patient seemingly realized the formerly denied cause of her troubles; and in a fourth case, latent homosexual wishes became evident. In all these cases, the uncovering, bringing into consciousness and discussion, of these highly emotional memories and self-deceptions caused a considerable diminution of tension and apparent relaxation of the patients. It was, perhaps, nothing more than the well-known process of catharsis, but, without the insulin coma, there were no means to uncover this hidden source of psychotic mechanism.

How insulin coma accomplishes the releasing of repressed memories and how it unmasks self-deceptions we do not know; but we do know that insulin oxidizes the glucose of the blood and thus removes the most important, if not the only, source of energy nec-



essary for the function of the brain. We know that the phylogenetically and ontogenetically youngest organs and tissues are the most sensitive to any change, and are so to anoxia. We know that, in organic lesions of the brain, recently acquired engrams vanish first. Thus one may presume that the frontal lobe, or wherever our highest mentations occur, is the first cerebral site to suffer from anoxia and is the last to recover. This hypothesis would explain the well-known fact that chronic cases respond much less than new cases to insulin-coma treatment, very likely because of the widespread association and organization of their psychotic mentation.

The neurotic and psychotic security and defense mechanisms are undoubtedly highly specialized and late acquisitions, so we again may presume that these functions are the first to be damaged and need the longest time to recover. It seems that, during the time of transition to unconsciousness and during the period from coma to consciousness, there is a temporary weakening, a breach, in the psychotic construction. The greater damage set would explain the greater productivity of unconscious material during the post-comatose state than during the pre-comatose, and that would explain the fact, too, that after a one-and-a-half-hour coma there is a greater productivity of such material than after only a one-hour coma. This could account for the disappearance often observed, of psychotic behavior during this post-comatose period and, inversely, for the appearance of hallucinations and other psychotic symptoms—in the second instance through weakening the conscious control. Dissimulating paranoid patients often produce their delusions during the post-coma state. The clinical improvement usually goes hand in hand with the alleviation of the pre- and post-comatose disturbances.

It seems that this specific action of insulin coma on the higher centers is the reason why insulin coma has hardly any effect in emotional psychoses, as in manic-depressive psychoses, depressions and catatonias. But in catatonies, after relieving the emotional tension by metrazol-convulsions or by combination of metrazol and insulin coma, the schizophrenic ideation can be modified. That would explain the well-known fact that insulin coma gives the best results in paranoid cases.

Against this theory it can be rightly objected that in many cases such relevant productions are not observed, or are neglected and



never discussed, and that the treatment still gives the usual beneficial effect. That is correct, but in observing improvement in the patients' condition during treatment, it is seen that gradual or abrupt change in behavior is usually accompanied by characteristic emotional reactions. These reactions are sometimes concealed with a smile by an otherwise sulky and depressed patient; or by an, "I am fine," answer to "How are you?" instead of the usual, "I am sick." Or a patient who, when waking up has invariably called for the nurse with a, "Mrs. Jones, let me up," one day calls another name. Or another patient who usually has been silly and manneristic when coming out of coma is suddenly well-composed. If we insist on questioning the patients about the cause of these changes we very often succeed in getting an explanation which suggests that their pathological ideations are somewhat altered.

One hears, for instance, a weeping patient answer the inquiry about the cause of her crying with, "I am awful homesick"—this from a paranoid patient who has accused her relatives and neighbors of making her home life unbearable. Another may ask, "When will I see my husband?" after having accused her husband of infidelity and cruelty, and having refused to speak to him on visiting days. Another may smile and upon questioning may answer, "I am so happy, I am pregnant." This patient has never had a child and has refused intercourse for fear of becoming pregnant. Similar occurrences are observed daily, but even if one does not follow and does not discuss them with the patients, the writer does not doubt they have some cathartic influences in allowing wishes and desires which were formerly repressed and hidden behind the psychotic construction to rise to the surface. If one enters actively into helping patients follow such impulses and ideas as are normal, this certainly assists them in removing or abandoning their pathological ideation.

Psychotherapists with orthodox analytical orientation will certainly find this technic very superficial and inadequate for analytical interpretation. The writer is well aware of the limitations of this procedure, but in a state hospital setting, even with very co-operative patients, it would be impossible to provide the time necessary for thorough analysis. All the patients mentioned are serious cases of dementia præcox, and one must be satisfied to get a modest glimpse into the pathological mechanisms. The material



gained must be used very carefully unless one wants to risk serious exacerbations, as often happen when deep-seated pathoplastic factors are touched.

Freudian psychopathology discovered that early childhood experiences are the roots of later neurotic or psychotic reactions. Conducting a psychoanalysis, one invariably meets them, but, before reaching them, invariably meets a great number of later conflicting experiences with similar emotional accent. By uncovering such experiences, we usually eliminate a barrier which liberates further repressed memories and, in the meantime, alleviates tension and anxiety. Considering these well-known facts, which are admitted even by the most conservative psychoanalyst, one should pay more attention to, and assign greater significance to, later experiences. There is no doubt about the pathogenic factors of early childhood experiences, but their importance is mainly in preparing or sensitizing the mental terrain for inadequate handling of adult experiences. The latter experiences, affecting vulnerable or sensitized persons, may cause or precipitate mental reactions known as psychonurosis or psychosis.

The perfectionist attitude of conservative psychoanalysts somewhat belittles these later experiences, demanding thorough analysis, a going to the roots. Of course that should be the ideal aim and procedure; but, and there are many buts, in most cases of neuroses and psychoses there are several reasons why thorough analyses cannot be carried out. Should we then, just because we are not able to offer patients "ideal treatment" abandon them to their suffering, or should we look for an available treatment—even if not perfect—that helps the patient to assume his pre-morbid life?

It is not the scope of this presentation to discuss these problems, but the writer thinks it necessary to point to the paralyzing and discouraging effects of such a conservative, but impracticable attitude, and necessary to try to justify short-psychotherapeutic measures. The "deep analytical" results in schizophrenia are not very encouraging; for example, Rosen's surprising results are criticized from authoritative quarters. The writer himself, after a long psychoanalytic and psychotherapeutic practice, is very doubtful whether psychoanalytic treatment of schizophrenics is at all possible, and if it is, whether it is not more harmful than beneficial.



The very poor ego organization of the schizophrenic is well known. This weak ego organization induces him to take the so-called schizoid attitude toward the outer world. This attitude protects him from frustrations which would result from his poor social adaptability. The schizoid character is a useful defense mechanism. As long as there are no stronger needs to break down the self-imposed limitations and barriers, or as long as the barriers are strong enough to withstand outer pressure, there is a weak but successful balance. If this balance is disturbed by whatever cause, schizophrenic disorganization follows. If one is able to channelize the schizophrenic's needs into, for him, acceptable expressions, or if one can enable him to evade greater pressure, it is possible to restore his pre-psychotic personality, and, with that, we have to be satisfied as long as we have no means for changing his personality. Lobotomy can be considered only as an ultimate sedative measure.

The writer is far from advocating the specificity of insulin-coma treatment of schizophrenia. As long as we do not know anything about the cause and nature of the schizophrenic process, and as long as we use the diagnosis of schizophrenia for psychopathologically dissimilar and etiologically unknown psychoses, there can be no discussion about specific treatment. But it can be said that at the present time insulin-coma treatment promises the best results, especially in the paranoid form of the disorder. The proper technical application and the establishment of an "accepting" environment are basic requirements. The creation of an atmosphere of friendliness, helpfulness and mutual understanding will help to reduce the genuine suspicion of schizophrenic patients; it will assist them in regaining their lost trust in human kindness which is essential to protect their sensitive egos. Systematic group-psychotherapy develops their ability for better interpersonal relationship and empathy.

The psychotherapeutic approach described here is a further tool in our hands offered by the insulin-coma treatment. If fully utilized, the writer believes, it will reward us with better and more durable results. Of course, one must keep one's distance from the organistic, "push button" orientation, and stop paying lip service to, while actually neglecting, the dynamic approach. Even if one believes in a primary organic basis of the schizophrenic process, for which, in fact, there is, as yet, no proof; the double, psychosomatic, determination of morbidity in general is today well-established.



lished common knowledge, successfully applied in all fields of medicine. Naturally there is need for more psychotherapeutic training, more ability in observation, and additional time for the routine insulin-coma treatment. As long as we are satisfied with giving a patient a so-called "course" of ECT and later on a "course" of insulin-coma treatment—and then believe that we did everything possible and blame inadequate methods for our failures—we neglect and betray the most important psychiatric therapeutic procedure, which is psychotherapy. More optimism and enthusiasm, less fatalism and resignation reflected in our approaches, are the first, and may be the most important, steps to gain the much-needed confidence of the frustrated patient.

The writer has presented some observations during the pre- and post-comatose periods of insulin-coma treatment of schizophrenics. He has tried to show that the peculiarities of behavior and the occasional verbal productivities of the patients allow a glimpse into the dynamics of the psychosis and offer a key to a psychotherapeutic approach. The writer believes that these possibilities, fully utilized, may considerably deepen our understanding of the psychic mechanism of schizophrenia and in the meantime better our therapeutic results.

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## FOLIE À TROIS\*

### *A Case Report*

BY FRANCIS C. BAUER, M. D.

The concept of transmitted psychosis, induced "insanity," or psychosis of association, is well known and sufficient evidence has been collected to establish the phenomenon as a clearly defined psychiatric entity. In his review of 103 cases, Gralnick<sup>1</sup> postulated certain requisites for diagnosis and formulated the dynamics of the illness, while adding appreciably to the number of reported cases of *folie à deux*. Since 1900, however, there have been only six reports of *folie à trois* appearing in the American literature and even fewer reports of transmitted psychoses involving more than three persons. Kallmann and Mickey<sup>2</sup> discuss a case of *folie à sept* and one of *folie à neuf*; but, since they do not present the degree of association among the patients and since, in some cases, the family members involved were widely separated for many years prior to the onset of illness, it is felt that their cases do not represent induced or transmitted psychoses. These authors suggest that the term should not be applied to patients having blood relationship although the latter is held by some to be prerequisite to the observance of the phenomenon. The case reported by Kesselman<sup>3</sup> involves a mother, her daughter and son-in-law, and that reported by Kepner<sup>4</sup> concerns two sisters and a brother.

It is felt that the following represents a case of *folie à trois* occurring in siblings, although from the family history one might consider it to be a case of *folie à cinq*. The patients observed were: George, 58, and his two sisters, Anna and Mamie, aged 53 and 49 respectively. They were admitted to Pilgrim State Hospital, West Brentwood, N. Y., as a family unit on November 13, 1951, having been referred for care and treatment by the Welfare Department of New York City. The case material was obtained from the patients and substantiated as far as possible by social service investigation. The patients were interviewed separately and gave almost identical data.

\*Presented at the downstate Interhospital Conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, New York, N. Y., April 9, 1952.



## FAMILY AND PERSONAL HISTORIES

The patients' mother was born in Italy and was separated from her family at an early age, to live and be educated in a convent school. Upon completing her studies at the age of 16, she was restrained by family pressure from entering the convent as a postulant. Some time later, following a clandestine courtship, she was prevented by her parents from marrying a man of her own choosing. She was forced, instead, to marry the patients' father who had previously been selected by both his and the girl's parents.

The mother confided to her children the fact that no love existed between herself and her husband. In spite of this lack, however, and, evidently prompted by religious principles, there was never a separation, nor was there any overt domestic discord.

The patients describe their mother as a lovable woman, a good and righteous individual, over-religious and extremely demanding. She effectively controlled the family group by means of a "nervous illness." Mamie stated, "Mother had spells of nervousness and headaches." This was elaborated by Anna, who added that the episodes also included shaking, dancing and the singing of hymns. She was subject to frequent periods of depression, and sudden mood swings were not unusual. She was apparently overprotective and aggressive regarding her family, and the recollections of the patients indicate that they were not often permitted to leave her side. She sent them to school reluctantly, encouraging them to remain away, and tutored them privately. They were not permitted to play in the neighborhood because their mother felt that there would be arguments with others which would ultimately reflect on her. In view of her attitude, the patients remained at home constantly when not at school and, from early childhood, were trained in domestic activities. They speak tenderly of their mother, protest "undying love" for her memory, and insist that they neither showed nor felt any hostility toward her, in spite of what was then recognized by them as an unusual home situation.

The father of the patients was a cabinetmaker, whose only avocation was playing the clarinet. The patients extol his virtues and comment enthusiastically when discussing the attention he supposedly lavished on the entire family. The mother's nervous attacks upset the father considerably and caused him a great deal of worry. He used her illness in an effort to dominate the children, frequently pointing out the necessity of their being good children



so that "mother would not have a spell." He "had no friends" and followed a rather rigid routine of daily activity during which he avoided contact with others as far as possible. He spent his free time with the children, either at home or, occasionally, in a nearby park. He was not over-religious but was a good church member. The patients deny ever having been afraid of their father, although they readily agree that he was strict, and they took great pains to be sure that things were always as he would want them.

The mother died in 1920, the cause not known, and, after four years of steady decline, the father died of a cerebral vascular accident.

The family consisted of seven siblings, five of whom were born prior to the parents' migration to this country. The first two children died in infancy and the third child died at the age of six. The causes of these deaths are not known. The fourth child, Anthony, was a mental defective who was cared for by the patients and who died in 1946, also of unknown causes. The last three of the group are George, Anna and Mamie, the patients. Throughout their entire association, there is no evidence of overt hostility among them, and the children were uniformly devoted to the wishes of their parents. The patients mention some resentment at being kept apart from other children, but their reaction to this is crystallized by Mamie in stating: "We were trained from early life to understand that we were different from other people. We didn't have any choice about living the way we did and I'm sure that we never really disliked it."

George started parochial school at the age of six, and, although he was not considered a good student, he never had to repeat a class. He was fairly interested in academic pursuits and at one time aspired to practise medicine. Because of economic circumstances and the presence of psychosis, however, he relinquished this idea and left school after completing the primary grades.

Anna, because she was the older of the daughters, was entrusted with household duties at an earlier age than her sister. One of her principal duties was the care of her mother during the latter's "nervous spells." For this reason, she did not begin school until the age of eight, and at that time was extremely reluctant to leave her mother in order to attend classes. She was not interested in anything taught her at school and preferred her mother's private tutoring.



Having finished six grades of school at the age of 14, Anna applied for permission to work and discontinued her education. She had become interested in needlework and had also expressed a desire to become a cloistered nun. Because of her mother's constant repetition of the injunction that Anna must never leave home, she gave up the idea of religious life and became a dress-maker. She revealed that, during her formative years, she was frequently requested to join her schoolmates in social and athletic activities but, because she was never permitted to do so, she was later rejected by the group.

Mamie's education was perhaps more traumatic. She began school at the age of six, attending the same parochial school as her elder siblings. In the second grade however, she had considerable difficulty with the nuns in charge, was said to have been frequently disobedient and, on one occasion, was struck by one of the teachers. In spite of her desire to leave, she remained at school, at the request of her parents, until the age of eight. At this time, she was transferred to a public school in the neighborhood and was dismayed at being put back two grades in the process. During her school years, Mamie complained frequently of earache which caused her to remain at home. She was disinterested in school and did not see the necessity of learning to read and write. In the second month of the seventh grade, she left school after having applied for permission to work.

While George was permitted to work away from home, this privilege was not extended to Mamie or Anna. Of the two, Anna was permitted to accompany her father daily to a factory where she obtained the necessary materials and patterns for herself and her sister. She then returned home in the company of her father; and the two girls engaged in dressmaking and embroidery, completing all the work at home under the supervision of their mother. Upon completing the work, Anna was escorted back to the factory by her father in order to turn in the finished products and obtain new materials. Their work was evidently satisfactory and they continued with steady employment until approximately 1946. Following the death of their parents, Anna was accompanied by George and the same working conditions were preserved.

There was obviously little opportunity for companionship and friendship. The children formed a closely-knit group and rejected all outside interference. They were able to tolerate each other



fairly well but were extremely self-conscious when in contact with anyone alien to the family group. They were exquisitely sensitive to criticism, felt "different" and apart from others their own age, and felt, realistically, that people in the neighborhood were talking about them. None of the family had any special social interests or hobbies and, in spite of their own recognition of their rather unusual place in society, the prevailing mood was one of happiness. Because their early training did not permit it, they did not later seek recreation or enjoy it when it came unsought. The only luxury permitted was a radio which was in constant use. None of the siblings was interested in the theater, and Mamie cannot recall ever having seen a talking picture.

No sexual instruction was given to any of the children; and at the time of admission to the hospital, both Anna and Mamie had only an incomplete and hazy idea of the biology of reproduction. Anna learned about menstruation from a schoolmate at the age of 10 and felt at the time that she was being drawn into a "dirty conversation." Menarche occurred at 12 and caused her to react in a hysterical fashion. When she sought her mother's help, she received no instruction other than that concerning personal hygiene. In discussing relationships with men other than her brother, Anna recalled having been attracted to only one male and hastily amended the memory with a denial of having ever entertained the thought of marriage. Mamie had no ideas on the subject of menstruation and, although she shared a bed with her sister, had never observed the phenomenon until, with the onset of her own menses at the age of 12, she, too, cried and became hysterical. She felt that she was going to die, and turned to her mother but received neither instruction nor support. In relating these facts, Mamie stated, "You see, we were all bashful people in our house. We never kissed like other people and I don't think I ever heard the word sex except maybe once or twice."

Both sisters refused to undergo gynecological examination at the hospital and consciously related their refusal to the fear of pregnancy. When informed of this, George became quite concerned and argued with his own physician that the virginity of his sisters must be protected. George had a limited knowledge of sexual matters through his contacts with work associates. He planned at one time to marry but, following the death of his par-



ents, felt it his duty to remain with his sisters in the capacity of provider and protector.

The patients are all members of the Roman Catholic Church and have been very attentive to religious activities. Throughout childhood and during most of their adult life, George and Anna have attended daily mass. Mamie discontinued the practice in later years because she was ordered to do so by an hallucination. She was permitted to attend church on Sunday but only in the company of her elder sister.

### PSYCHOSIS

It is impossible to date the onset of psychosis individually or collectively, but an attempt has been made to treat the development of symptoms chronologically.

George was the first of the family to experience hallucinations, which have been restricted almost exclusively to the visual sphere. In 1900, at the age of eight, George frequently saw "beautiful musicians" whom he characterized as angels. They played only stringed instruments, but the music was never audible. In addition to his orchestral hallucination, George was frequently able to see the Pope who invariably bestowed upon him the apostolic benediction. When he reported these experiences to his parents, he was told that he should consider himself an extremely privileged and singularly honored individual to be able to see the Pope, and was encouraged in his personal sanctification so that he might later have visual communication with the saints as well. The frequency of his experiences is not known, but it has been firmly established that the phenomenon made George an important member of the family constellation.

Approximately two years after George's initial experience, Anna was attending her mother during a "nervous episode," and prayed to St. Anthony that her mother might be cured. She reports that she "sensed a stillness and saw St. Anthony filling a cornucopia pipe." The patient half-humorously added that she was shocked at seeing a saint smoke. She reports further that she asked the saint to help her mother and that he did not speak but nodded and disappeared. She revealed this experience to her mother and, quoting the latter's reply, stated, "It is because you are very pious. Shut yourself up to pray." None of the family members was disturbed by these experiences, and both parents were apparently



pleased at their gifted children. Anna considered this an unusual experience and George felt some annoyance at the challenge to his unique position in the family group. Soon after Anna started to hallucinate, and possibly stimulated by competition, George showed an almost pathological interest in the occult. He read many books on hypnotism and spiritism, and, attracted by the potentialities of telepathy, undertook many private experiments in an effort to communicate with others, both living and dead. He was universally unsuccessful in these attempts but frequently regaled his sisters with accounts of the world beyond and the possibility of contact with spirits. Anna remained non-committal, and Mamie openly scoffed during these recitations.

Following the death of the patients' father in 1924, all three were simultaneously startled by a knocking sound emanating from a closet in their home. The sound continued even after thorough investigation revealed no apparent cause and after all the neighbors had been interrogated. Having discussed the matter among themselves, the group decided to accept this as a communication from their dead father. In spite of his reading, George became terrified at this experience and insisted that they live with an aunt for a two-week period. When the experience was repeated, following their return to their own apartment, George, then the nominal head of the family, was pressed for further explanation. He revealed that prior to his father's death, the latter had indicated that their apartment should be vacated within a month after his demise. It was conveniently noted that the end of the first month after this event was rapidly approaching, and the family relocated in new quarters.

George had apparently been free of hallucinations at this point, but Anna's ability to see visions of the saints and "golden angels" was increased to the point of daily visitation. She was never conscious of an auditory component to the hallucinations. Although Mamie had no experiences of her own to relate, she never doubted the validity of those described by George and Anna.

There is little available information concerning the family during the next 20 years. All three continued to work, Anna and Mamie at embroidery and dressmaking, and apparently made a fair economic adjustment. There was no outside interference, and the patients continued to function within the framework of their own seclusive society. Anna had attained dominance in the group,



since George claimed only infrequent audience with the Pope. On January 12, 1945, a date well marked in her memory, Mamie had her first hallucinatory experience which, unlike those of her siblings, was entirely an auditory phenomenon. She heard a voice which she was unable to identify and which directed her to discontinue the practice of sleeping with Anna. Her announcement of this directive provoked passive hostility on the part of Anna and frank admiration from George.

George reacted with envy at a later time however, based on the premise that his investigation and study best qualified him to be the subject of an auditory hallucination. It must be noted that, after Mamie had remained in the background for 20 years, her ability to hear voices gave her considerable status in the group and had an appreciable impact on the family equilibrium. Soon after her initial experience, she began to control the activities of the entire family by means of her hallucinatory directives. She was not usually permitted to transmit messages directly but did so by means of a ouija board which is still used occasionally in the family circle. On special occasions, the family would convene at early hours of the morning and faithfully transcribe the messages which were related by Mamie. In a series of directives which were obviously wish-fulfilling, it became apparent that Mamie would be married; the family would be elevated to an exalted position in the neighborhood; within a year they were to enjoy considerable wealth; the family dog was henceforth to be treated as an angel; George was to discontinue working on February 1, 1946.

During the inevitable testing operations on the part of George and Anna, it soon became apparent that if the messages received by Mamie were not acted upon, various members of the family would be stricken with paralysis. After several unpleasant experiences of this kind, there was little disobedience.

February 1946 marked the death of Anthony. Up to this point, little has been mentioned of the eldest sibling who had continued to live in the family group and was cared for by the others. As far as can be ascertained, he was a mental defective who could not speak and who had inadequate control of his muscles. He was treated with a great deal of respect by his brother and sisters and it can be inferred from their statements concerning him that they considered his defective state to be of significant divine origin. Anthony's illness began in 1945 and, because Mamie had received



instructions to the contrary, no physician was summoned. This culminated in the first episode of overt disagreement in the entire family history. George and Anna became very disturbed over Anthony's downhill course and, in direct contradiction of Mamie's orders, called a physician. Because of this contradiction and in keeping with another of Mamie's predictions, Anna became violently ill, and it was felt that the group was being punished for disobedience.

It was decided, therefore, that, although prescriptions had already been obtained, the medicine should not be administered to Anthony. As a result of this neglect, he died on February 1, 1946 of unknown causes. This date, it will be remembered, was previously marked as the last on which George should be gainfully employed. A considerable part of the family resources was spent on Anthony's funeral for which two complete sets of clothing, including overcoats, were purchased for him and buried with him. Following the funeral, George remained away from work for two weeks, which was felt to be a suitable period of mourning. He was told upon his return however that, because of his unexplained absence, his place had been filled, and his services were no longer required. George subsequently requested assistance from the New York City Welfare Department.

Within a period of six months, Mamie had received further directions to the effect that both she and Anna must give up embroidery and dressmaking, and both entered their names on the relief roll. She was also instructed not to appear alone in public and never again left the house. The family unit, now reduced to three in number, reached another equilibrium between 1946 and 1951, although it is felt that there was growing hostility on the part of George and Anna who were now completely dominated by Mamie's auditory hallucinations.

Mamie finally was requested by her siblings to consult a physician. In preparing for this, during one of her early morning conferences with the family, Mamie indicated that the consulting physician would probably recommend psychiatric treatment, which suggestion was to be ignored; and she reminded the group of the penalty for disobedience. When the doctor did, in actuality, recommend shock treatment for Mamie, her status was further augmented and she was now considered by the family to be a prophetess. It was felt that the expense of private treatment could not



be tolerated and Mamie received no electric convulsive therapy. Shortly after the suggestion was made however, she began to experience a feeling, not unlike electricity, which began in the genital region and spread to various parts of her body. In describing the treatments, Mamie stated: "I would lie on the bed, face down, and see a likeness of the doctor with his hands moving all the time. After a little while, I would feel a strange thing in the place down here [indicating by gesture the genital area]."

These "treatments" continued for some time, and Mamie's power as the directing force of the family also increased. Various household duties were now delegated to other members until, ultimately, Mamie's sole function was to receive and transmit directions while George and Anna ministered to her.

During the ensuing years, the delusions and hallucinations became more bizarre and embraced every aspect of the family life. On one occasion they were told to prepare dinner for nine people; and, when the preparations were completed, Mamie ordered that everything connected with the proposed meal, including the utensils used getting it ready, was to be destroyed. These instructions were accurately followed, and, because of an absence of cooking utensils, the family went without food for three days. Mamie then supervised the preparation of a feast, following which rigid dietary regulations were observed.

In accordance with one of her earliest messages, Mamie selected as her prospective partner in marriage a dentist who had treated her 15 years earlier. She began a correspondence with him and observed an elaborate ritual in writing the letters. The notes were written and signed in Mamie's own blood after George and Anna had incised her finger and a special pen had been purchased. The letters were mailed at 3 o'clock in the morning from the post office at Pennsylvania Station.

There are a host of similar experiences which cannot be presented here. Although attention has been focused on Mamie as the dominant figure, it should be remembered that, during this entire interval, Anna continued to be visited by the saints, and George continued to have occasional visits from the Pope. The events leading to the patients' hospitalization took place early in 1951. George was again obtaining prominence by more frequent hallucinatory audiences and was the envy of his sisters as the frequent recipient of the papal benediction. Anna maintained her



status and Mamie was apparently less powerful in the family constellation.

The doctrine of reincarnation was then introduced by Mamie through the medium of her hallucinations and seized as the explanation for many of their previous experiences. The physician who had recommended shock treatments for Mamie was revealed to be the patients' father reincarnate. The social worker assigned to the case by the Welfare Department was identified as a half-brother, born of the union of the patients' mother and her first lover whom she had been forbidden to marry. Anthony was reincarnated in various forms, as a golden angel, as the family pet, but more frequently as the doctor sent by the Welfare Department. Because of constant misidentification of persons and the destruction of household property, the family became a problem to the welfare authorities as a result of which the patients were referred to Bellevue Hospital for observation.

At Pilgrim State Hospital, the patients were always extremely co-operative, pleasant and agreeable. The two sisters were inseparable and none of the group was overconcerned about being hospitalized. Various members of the hospital personnel were identified as reincarnated relatives and were incorporated into the patients' system of delusions. Their course at the hospital was initially uneventful until they were transferred from the admission buildings. An effort was made to keep the unit together, but, once separated, George preferred to remain as far away from the building in which his sisters lived as the hospital grounds would permit. He gave no reason for this other than the fact that he was enjoying his work in caring for other patients on his ward. Psychological tests revealed all three patients to be of average intellectual endowment; observation indicated a diagnosis of dementia præcox, paranoid type in each case.

#### CONCLUSIONS

In evaluating the foregoing material dynamically, it is felt that the case represents an example of sustained sibling rivalry and the acting out of repressed hostility. It is apparent from the information given, that the mother had been descriptively psychotic and, possibly in his attempt to please her, George became the first of the family to experience hallucinations of a religious nature. Anna apparently lost favor until she, at a later time, also developed



an hallucinatory system. Underlying this, one sees the competition which must necessarily have existed among the family members. It is felt that Mamie acted out her hostility and, after a 20-year latent period, satisfied her competitive needs by emerging as the dominant member of the family unit. It is of further interest to note that in the acting out process, she ultimately became the exalted member whose personal needs were attended to by the siblings virtually reduced to slavery.

In spite of conscious denial, the resentment harbored by the patients toward their mentally defective brother is clearly shown by the neglect which resulted in his death. The attendant guilt was expiated first by the elaborate funeral arrangements and much later by his reincarnation as a physician.

The father's reincarnation as a physician who, in a delusional sense, treated Mamie, satisfied the need to elevate the father; and the sexual connotation attendant upon this aspect of Mamie's illness is apparent. The wish-fulfilling character of these reincarnations is of interest, especially when one considers that the patients' mother was never so honored.

Once established, the reciprocal delusional experiences of the three patients involved reached several equilibria, with each becoming alternately a dominant figure, ultimately to give way to another. Once the equilibrium was destroyed by hospitalization, George was apparently relieved to be free of Mamie's dominance and of the need to protect his sisters whose care was now insured.

#### SUMMARY

Since 1900, only six cases of *folie à trois* have appeared in the American literature. In these, as well as in numerous reports of *folie à deux*, the factors of close association, relationship, and chronology of symptom formation have been stressed.

A case of *folie à trois* involving a brother and two sisters, in which the duration of illness is almost 50 years, has been presented for consideration.

The principal mechanisms involved in this case are considered to be sustained sibling rivalry and the acting out of repressed hostility.

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June 1952



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# OBSERVATIONS ON 36 PATIENTS WITH GENERAL PARESIS TREATED WITH PENICILLIN-MALARIA AND PENICILLIN ALONE

BY WERNER M. COHN, M. D.

The purpose of this paper is to report on treatment results, clinical and serologic, in a group of 36 patients with syphilitic meningo-encephalitis, treated with penicillin-malaria and penicillin alone. Various data of prognostic importance will be presented. Observations on the three aspects under which the disease manifests itself—psychiatric; physical, especially neurologic; and serologic—will be discussed separately and supplemented by brief references to the literature.

From more recent publications it appears that with the increase of time for observation the controversy over penicillin alone as against penicillin-malaria in the treatment of neurosyphilis has lost some of its vigor. While most papers of the years 1948 and 1949 stressed the superiority of combined treatment (Rose,<sup>1</sup> Curtis et al.,<sup>2</sup> Goldman,<sup>3</sup> Watson,<sup>4</sup> Kierland and O'Leary,<sup>5</sup> Spiller and Stewart,<sup>6</sup>) other authors (Dattner-Thomas,<sup>7</sup> Stokes and Gammon,<sup>8</sup> Parkhurst and Bowman,<sup>9</sup> Weickart,<sup>10</sup>) had already reported at this time on highly satisfactory results with penicillin alone. Curtis has now revised his opinion.<sup>11</sup> In the years 1950 and 1951 only a few authors preferred the exclusive use of the combined treatment.

The present consensus may be summarized: Most authorities regard treatment with penicillin alone as sufficient; but in cases of severe paresis, and in cases of taboparesis and optic atrophy, combined treatment is still considered by many the treatment of choice.

## MATERIAL AND CHOICE OF TREATMENT

The material reviewed comprises 36 patients treated with penicillin-malaria and penicillin alone in a 400-bed service which for many years has performed the treatment of all male cases of neurosyphilis admitted to Hudson River (N. Y.) State Hospital.

At the beginning of 1949, penicillin was added to all malaria treatments. From June 1950 on, penicillin alone was the only treatment used for new admissions. A few patients had already been treated with penicillin-malaria prior to 1949.

The series presented includes all new admissions from January 1949 until May 1951 and also five patients who previously had been treated in the hospital with malaria-penicillin.



Eighteen patients in the series were treated with penicillin-malaria and 18 with penicillin alone. The equal numbers of these two groups are merely coincidental.

The *date of infection* was known in 18 cases (50 per cent). The average interval which had elapsed from the time of infection until hospitalization amounted to 19.8 years for 16 of these patients. The remaining two patients suffered from congenital syphilis.

The *average age on admission* was 49.7 years for all cases together, 46.8 for the patients who showed improvement and 50.8 for those who remained unimproved.

The *average duration of symptoms until hospitalization* was 17.6 months for all patients, 9.1 months for the improved and 20.9 for the unimproved.

The *average duration of hospitalization* was 5.9 months for the 10 patients who improved and could be discharged and 30.9 months for the patients remaining in the hospital at the time of this writing (1952).

#### METHODS OF TREATMENT

*Penicillin-malaria.* A tertian malaria strain was used which was preserved in the service by inoculation from one patient to another. A few patients who did not take tertian malaria required inoculation with quartan strains which had to be obtained outside. Inoculation was routinely performed by intravenous injection of 4 to 8 cc. of blood. The difficulty in taking malaria in the Negro race was illustrated by one patient who required five inoculations and finally terminated it spontaneously after three chills. The goal was 50 hours or more of fever over 103°. This was reached by 11 patients only (61.1 per cent). The penicillin used in the combined treatment was aqueous penicillin started at the height of the first paroxysm and given every three hours in around-the-clock doses until a total of 8,000,000 units had been reached.

*Penicillin alone.* A brand of penicillin containing 300,000 units procaine penicillin and 100,000 units aqueous penicillin per cc. was given daily for 20 days up to a total of 8,000,000 units.

#### COMPLICATIONS

Among the 18 cases treated with malaria-penicillin, complications occurred in seven patients (38.8 per cent), necessitating termination in six cases (33.3 per cent).



*Jaundice.* Severe jaundice was observed in three patients after 54, 43, and 12 hours respectively of fever over 103°. Malaria had to be terminated in all three cases. A fourth patient became jaundiced five weeks following malaria therapy with 58 hours of fever. The icteric index in this case was greater than 100, and the cephalin-flocculation test 2 plus. Following treatment with low fat, high carbohydrate diet, liver extract, and vitamin B<sub>1</sub>, the icterus subsided after three weeks duration.

*Circulatory collapse*, alarming enough to require immediate termination, was encountered in two cases.

*Projectile vomiting* and marked prostration after the first chill was the reason for discontinuation of malaria in the sixth patient.

No deaths occurred during or after malaria therapy.

No penicillin reactions were observed.

### RESULTS

In Tables 1 and 2 the clinical and serologic results in the penicillin-malaria and the penicillin-alone group are demonstrated.

Table 1. Clinical Results

Type of treatment	Much im- proved	Im- proved	Slightly im- proved	Unim- proved	Deaths	Totals
Penicillin-malaria .....	7 (7 discharged)	4	3	3	1	18
Penicillin alone .....	2 (3 discharged)	3	6	4	3	18
Totals .....	9	7	9	7	4	36

From Table 1 it is evident that the clinical results in the cases treated with penicillin-malaria were better than those in the cases treated with penicillin alone. Satisfactory clinical results (much improved and improved) were achieved in 11 patients (61.1 per cent) treated with penicillin-malaria as compared with only five patients (27.7 per cent) treated with penicillin alone. From the former group, seven patients (38.8 per cent) were discharged, and from the latter group only three patients (16.6 per cent). There are, however, several factors which decrease the apparent significance of the superiority of combined treatment: (1) The number of cases is small; (2) the average age in the penicillin-malaria group happened to be lower than in the penicillin-alone group, and (3) the patients in the combined group were followed up longer,



as their treatment had been finished before June 1950, as was mentioned before.

In Table 2 are demonstrated the serologic results which were obtained between six months and three years after termination of treatment. These are based on the Dattner-Thomas formula of spinal fluid activity. The serologic findings other than cell count and protein will be presented later. In this table, "no activity" comprises a cell count up to 4 and protein up to 30 mg. per cent. "Little activity" was arbitrarily defined as a cell count up to 8 and protein up to 60 mg. per cent. The results can only be shown for 33 patients because one patient died before his spinal fluid control was due, and two of the discharged patients could not be followed up.

Table 2. Serologic Results (33 Cases)

Type of treatment	No activity	Little activity	Unchanged or increased activity	Totals
Penicillin-malaria .....	7	9	1	17
Penicillin alone .....	4	9	3	16
Totals .....	11	18	4	33

There is again evidence that penicillin-malaria was superior to penicillin alone. For the evaluation of the spinal fluid findings the same reservations are valid as have been made for the clinical results.

#### OBSERVATIONS AND COMMENTS ON PSYCHIATRIC ASPECTS

It is well known that the clinical picture depends mainly on two factors which are also of major prognostic importance: (1) the degree of impairment of the intellectual functions, and (2) the type of psychosis.

#### *Impairment of Intellectual Functions*

The degree of impairment of intellectual functions is of the utmost importance since it reflects directly the extent of the structural cerebral changes. It is generally agreed upon that the less deterioration that is present before start of treatment, the better the prognosis.

In order to determine the severity of impairment of the intellectual functions on hospital admission, the mental status was sub-



jected to a detailed evaluation. The different degrees of intellectual impairment were designated as mild, moderate, and marked. Classifying the material according to these terms, significant differences were obtained in a comparison of the improved with the unimproved cases. *Mild* impairment was present in eight (50 per cent) of the improved and in only three (15 per cent) of the unimproved. *Moderate* impairment was present in six (37.5 per cent) of the improved cases, as compared with three (15 per cent) of the unimproved cases. *Marked* impairment was found in only two (12.5 per cent) of the improved, and in as many as 14 (70 per cent) of unimproved patients.

The method of utilizing the mental status for the evaluation of the intellectual functions is necessarily less exact than the application of psychological tests. Test methods have more recently been used by two authors (Goldman 1948,<sup>8</sup> and Sternberg 1950,<sup>12</sup>), both employing the Bellevue-Wechsler test.

#### *Types of Psychosis and Correlation with Pre-Psychotic Personality*

The official classification does not provide for any subgroups in psychoses with syphilitic meningo-encephalitis. For a more detailed study than this classification affords, subdivisions are, of course, essential. Kraepelin's well-known classification into four types (expansive, agitated, demented, and depressed) is still widely used. As regards the relation of psychosis to pre-morbid personality it has been for many years a matter of common knowledge that, apart from the intellectual deterioration, the type of pre-psychotic personality determines the type of psychosis. It is, however, not always observed that the normal personality develops a simple or dementing type of psychosis, the schizoid personality a schizophrenic-like psychosis, and so on. In the present material a direct correlation between pre-morbid personality and type of psychosis could sometimes not be established, and reference will be made to these situations in the discussion of the different subgroups.

In Tables 3 and 4 are demonstrated the distribution of pre-psychotic personality types and the types of psychosis.

The different psychotic types will now be elaborated upon in some detail.



Table 3

<i>Pre-psychotic personality</i>	
Apparently normal .....	20
Unstable .....	3
Schizoid .....	3
Psychopathic .....	2
Unknown .....	8
	36

Table 4

<i>Type of psychosis</i>	
Simple or dementing .....	12
Expansive .....	9
Agitated .....	2
Depressed .....	1
Circular .....	1
Schizophrenic-like .....	3
Unclassified .....	8

36

1. *Simple or dementing types.* Under this heading are listed those patients who showed different degrees of intellectual impairment with or without emotional dulling but who did not display major mood swings or special trends. Only two (16.6 per cent) of 12 patients in this group improved.

2. *Expansive types.* The pre-morbid personality of the patients classified in this group was commonly described as outgoing. The terms expansive and manic are often used synonymously. "Expansive," however, is preferred for the series presented, all patients listed in this group having shown pronounced delusions of grandeur in addition to euphoria, elation, psychomotor hyperactivity and impairment of intellectual functions. Hypomanic or mild manic states resembling functional psychosis were not observed. Neither was there a patient with previous manic or depressive attacks where the paretic process could have precipitated an affective psychosis. The favorable prognosis in this psychotic type was reflected in the improvement of seven of the nine patients in this group. The two patients who did not improve became demented eventually.

3. *Depressed types.* Only two patients with prolonged episodes of depression were observed, one of the two being listed in the circular group. Both depressions lacked entirely the emphatic and spontaneous character seen in depressions with manic-depressive psychosis, the depression being dull, flat, and overshadowed by confusion and sensorial defects.

4. *Circular types.* One patient whose depressive episode was just referred to had on admission presented a full-fledged expansive picture. It was interesting to note that nothing in this patient's pre-morbid personality pointed to a cycloid or syntonie in-



dividual. A brother of this patient, cared for in the same service and also suffering from general paresis, had a definitely schizoid personality make-up.

5. *Agitated types.* This type—formerly called by some galloping paresis—has, in general consensus, a poor prognosis. One of the two patients in this group remained in a state of continuous hyperactivity, finally refused to eat, and died six weeks after admission in spite of intravenous fluid therapy. He had been treated with penicillin alone. The other patient, who showed a marked admixture of manic features—the pre-psychotic personality being of schizoid make-up—eventually improved.

6. *Schizophrenic-like types.* The schizophrenic-like types are of interest, not only from a psychopathologic, but also from a prognostic viewpoint. All authors agree that their prognosis is less favorable than that of other types. Kopp and Rose<sup>13</sup> found improvement in only 25 per cent of their schizophrenic-like cases as compared with 90 per cent of cases with manic-depressive symptomatology. Likewise Landau<sup>14</sup> reported improvement in only a fourth of his patients with schizophrenic-like symptoms while two-thirds of the demented group improved.

As evident from Table 4, the present material comprised three patients of the schizophrenic-like type. One improved, two remained unimproved. One of the two unimproved cases corresponded to what some authors have called paranoid-hallucinatory psychosis and attributed to the effect of treatment with arsenicals or malaria. This patient had, on admission, been markedly expansive; and it was not until a month after termination of malaria that he began to react to auditory hallucinations and to express many delusions of bodily influence which have persisted for several years until today. Dattner<sup>15</sup> summarized the theories offered on the pathogenesis of this syndrome as follows: Paretics are liable to develop this picture when there is (a) constitutional disposition or (b) depressed liver function caused by acute or chronic intoxication. The present patient neither had a constitutional predisposition—his pre-morbid personality being obviously outgoing—nor was there evidence of impaired liver function.

7. *Unclassified types.* In addition to the foregoing groups, there are cases which cannot be properly classified under any of the types just described. Of the eight patients listed under this heading, two showed mild intellectual changes only, three also dis-



played emotional instability, one showed mild paranoid ideas, and one had transitory visual and auditory hallucinations precipitated by alcohol. In the eighth case, an acute alcoholic hallucinosis was superimposed upon an asymptomatic paresis.

#### OBSERVATIONS AND COMMENTS ON PHYSICAL (ESPECIALLY NEUROLOGICAL) ASPECTS

*General paresis and taboparesis.* Of the 36 patients, 26 suffered with paresis and 10 with taboparesis. The proportions of these diseases were 13:3 in the improved, and 13:7 in the unimproved group, that is the taboparetics constituted only 23 per cent of the improved and 53.8 per cent of the unimproved patients. While there was no apparent difference in the psychoses of paretics and taboparetics, the neurologic manifestations of the tabetic patients were of comparatively mild character. With the exception of one patient whose lower extremities eventually became paralyzed and who died of intercurrent infection, none of the patients showed progression of symptoms. All nine were able to walk. No gastric crises were observed; lancinating pains were rarely complained of; and there was no patient with severe tabetic arthropathy.

*Neurologic signs.* The most common neurologic signs (paresis and taboparesis combined) were in order of frequency: Pupillary changes (Argyll-Robertson, fixed, or sluggish) in 28 patients (77.1 per cent), dysarthria in 24 patients (66.6 per cent), abnormal knee jerks in 22 patients (61.1 per cent), impaired gait in 19 patients (52.7 per cent), dysgraphia in 17 patients (47.2 per cent), abnormal ankle jerks in 17 patients (47.2 per cent), and positive Rombergs in 10 patients (27.7 per cent).

Little change of neurologic signs after treatment was observed with the exception of improvement of gait and co-ordination and occasionally very striking improvement of dysarthria.

*Apoplectic and epileptic symptoms.* In six patients the disease became manifest with cerebrovascular accidents resulting in hemiplegia and hemiparesis respectively. There was permanent hemiplegia in two cases, permanent hemiparesis in one case, and only minimal residuals in two patients. The sixth patient showed improvement of motor functions of the extremities, but his motor aphasia, agnosia, and apraxia persisted.

Convulsive seizures before admission, but not observed in the hospital, occurred in two patients. Three were admitted to general



hospitals for epileptic attacks and subsequently transferred to the state hospital. Two of these three patients were cases of juvenile paresis. Three other patients suffered seizures for the first time while in the hospital. Five patients had grand mal seizures only, one patient both grand and petit mal seizures. As a rule, the seizures responded to anticonvulsive medication, as well as other forms of symptomatic epilepsy do. Status epilepticus, however, occurred in two patients. It could not be controlled in one, who died of it. The second patient—almost moribund—could be saved.

*Optic atrophy.* There was one case with optic atrophy. The patient was treated with penicillin-malaria and progressed.

*Deaths.* The mortality rate was 11.1 per cent (four patients). In three patients, the cause of death was directly related to the paretic process. Mention has been made of these three cases elsewhere. The fourth patient died following a mid thigh amputation for peripheral arteriosclerosis.

#### *Combination of Paresis with Other Organic Diseases*

*Arteriosclerosis.* Many patients were in the arteriosclerotic age group, and arteriosclerosis often contributed to neurologic and psychiatric signs. While the differentiation between syphilitic and arteriosclerotic heart disease was often difficult—heart disease was present in eight patients—it was in almost all cases impossible to evaluate the role played by associated cerebral arteriosclerosis.

*Trauma.* The influence of head trauma has occasionally to be appraised. In one patient, it was at least a contributory factor. This man—a truckdriver—was found below his truck in a convulsive state. During hospitalization he showed a right hemiplegia; and a skull x-ray revealed a fracture through the left os occipitale. It could not be ascertained in this case if the convulsions were caused by the head trauma or were preceded by it.

*Alcoholism.* Combinations of paresis with alcoholism have already been mentioned.

#### OBSERVATIONS AND COMMENTS ON SEROLOGIC ASPECTS

The validity of the concept that the spinal fluid reflects accurately the state of the neurosyphilitic process is generally recognized. Most authors agree with Dattner-Thomas that cell count and protein are exact indicators of the activity of the syphilitic process and that indication for, and extent of, treatment depend



mainly on these two factors. It appears of interest to mention that the Dattner-Thomas concept has occasionally been disputed in the literature. Grover,<sup>16</sup> having examined 1,632 neurosyphilitic cases, concluded that the spinal fluid Wassermann is a more accurate index of parenchymal activity in paresis than cells and protein, and is a more accurate prognostic guide; while Goldman,<sup>3</sup> reviewing 140 cases, felt that cell count and protein are so susceptible to even the most inadequate treatment that they can hardly be used as a key to therapeutic results.

In this paper, the Dattner-Thomas concept has been adhered to.

In reviewing blood and spinal fluid findings, it was interesting to note that one month after termination of treatment the cell count had already returned to normal in four cases (two treated with penicillin-malaria and two with penicillin alone) and the protein had diminished more than 10 mg. per cent in 14 cases (seven treated with penicillin-malaria and seven with penicillin alone).

Cell count and protein values in 33 patients checked between six months and three years after termination of treatment have already been demonstrated under treatment results.

It remains to report on changes in blood and spinal fluid Wassermanns and in colloidal gold curves. Because of the limited time of observation, no marked changes in these values were to be expected.

The *blood Wassermann* became normal in no case. The titer decreased markedly in seven cases (four treated with penicillin-malaria and three with penicillin alone).

The *spinal fluid Wassermann* became normal in one case (treated with penicillin alone). The titer dropped from above 10 to below 10 in six cases (four penicillin-malaria, two penicillin alone).

Decrease in the *colloidal gold curve* occurred in five cases with initial D-curves, two changing to C-curves and three to B-curves. (Three of these patients were treated with penicillin-malaria, two with penicillin alone.) Reversal to normal curves occurred in no case.

#### CORRELATION OF SEROLOGIC AND CLINICAL RESULTS

*Serology and psychosis improved*: 21 cases, slight clinical improvement included (12 penicillin-malaria, nine penicillin alone).

*Serology and psychosis unimproved*: three cases. Two patients died. (All were treated with penicillin alone.)



*Serology unimproved but psychosis improved*: one case (treated with penicillin alone). The serology remained unimproved in spite of re-treatment.

*Serology improved but psychosis unimproved*: eight cases (one died). (Three were treated with penicillin-malaria, five with penicillin alone.)

The last of the four possible combinations—serology improved but psychosis unimproved—is the most unsatisfactory one from a therapeutic viewpoint. Two explanations are possible: (1) The irreversible cerebral damage is too far advanced; (2) affective or trend-reactions may persist independently of the course of the neurosyphilitic process.

Most of the unimproved cases belonged to the first group.

There are, however, situations, where the lack of correlation between serologic and clinical findings is more complex. This series included three re-admissions, all three patients having been well-adjusted outside the hospital for more than two and one-half years. All three patients presented an acute parietic psychosis, the severity of which was not reflected in the spinal fluid findings which showed but little evidence of activity.

In such cases, which occur occasionally, one must rely on the clinical aspects alone in evaluation of the parietic process and, in closing, the writer would quote Rose, who, reviewing neurosyphilis in the *American Journal of Psychiatry*,<sup>17</sup> said: "We, as therapists, should not lose sight of the patient in our efforts to destroy the invading spirochete."

#### SUMMARY AND CONCLUSIONS

1. Of 36 patients with general paresis, 18 were treated with penicillin-malaria and 18 with penicillin alone.

2. Choice and methods of treatment, as well as complications, were described.

3. The prognosis in the series presented was found to depend mainly on (a) duration of symptoms, (b) degree of intellectual impairment, (c) type of psychosis, (d) combination with tabes, (e) age. These findings confirm often-reported observations by others.

4. Satisfactory clinical results (much improved and improved) were achieved in 61.1 per cent (11 patients) treated with penicillin-malaria and 27.7 per cent (five patients) treated with penicillin



alone. Satisfactory serologic results (available for 33 patients only) were obtained in 94.1 per cent (16 of 17 patients) in the combined group and in 81.2 per cent (13 of 16 patients) in the penicillin-alone group.

5. The clinical failure rate was 22.2 per cent (four patients) for the patients treated with penicillin-malaria and 38.8 per cent (seven patients) for the patients treated with penicillin alone; the serologic failure rate was 5.8 per cent (one of 17 patients) and 18.7 per cent (three of 16 patients) respectively.

6. Some superiority of the combined treatment remains even after allowance has been made for factors rendering the composition of the group treated with penicillin-malaria more favorable. Penicillin alone, however, outranks the combined treatment with regard to safety, lack of complications, and ease of administration.

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## ON BRONCHIAL ASTHMA: A CASE REPORT

BY ALBERT E. SCHEFLEN, M. D.

Emotional disturbances in asthma have been reviewed and discussed by such authors as Alexander,<sup>1</sup> French and Alexander,<sup>2</sup> Dunbar,<sup>3</sup> and Weiss.<sup>4</sup> Weiss felt that the attack represented a suppressed cry for the mother. Alexander emphasized the "repressed dependency upon the mother," rejection or frustration, as a precipitating cause, and the termination of an attack with confession or crying. He pointed out the respiratory difficulties that may be seen when a child attempts to suppress crying.

### CASE REPORT

Mary was born in rural Delaware in 1904. Her father used alcohol excessively, and the mother had heart disease. Mary was the youngest of four children. One brother was seven, a sister five, and another brother three years older. The older boy had asthma. The older sister gradually assumed responsibility for the household and for Mary. The brothers have detached themselves from the family. The writer can give no objective portrait of these people. Mary alternately idealizes and berates them for their intolerance and rejection. To the sister, who is apparently identified with the mother, Mary is ambivalent and overdependent, and seems to have been for years.

Mary didn't like school. She "couldn't learn," made poor progress, and quit at the legal age. She felt rejected by her teachers and once transferred to parochial school to "get more attention from the teachers." As an adolescent she was evidently overmodest, passive, outgoing, unhappy, "easily upset, inclined to cry, sickly, and pampered." The mother died when Mary was 16. The sister assumed responsibility and Mary fell into conflict with her. She became sexually promiscuous and, on occasions, drank heavily. After a day's drinking, it is said that she was "sick for days." She once had a lover's name tattooed on her thigh and she feels this makes her unlovable. At 20 she had a hysterectomy, presumably because of pelvic inflammatory disease.

In Mary's early 20's, the sister married and left the house. The patient became the father's housekeeper. She did a very poor job—between wandering away, apathy, and parapractic behavior or errors in judgment. She developed "spells" of falling and thrash-



ing in a clear state of consciousness, and these still occur, predictably, when she is rejected. She became increasingly withdrawn, preoccupied, autistic, and inappropriate in affect.

At the age of 35, she was admitted to a colony for the feeble-minded. Her Stanford Binet was 51; the Stanford Vocabulary 62, and the Army Performance Test 47. When "frustrated," she had a "spell," but she achieved a semi-employee status and commendably carried out her duties in the care of children. She was very dependent on the matron and untiring and solicitous to her small charges. At the age of 41, however, she developed the delusion that she had killed the superintendent. She became depressed, self-deprecatory, and agitated. She plucked out her eyebrows. She was transferred to Delaware State Hospital, Farnhurst, Del., in 1945. On arrival she was mute, stuporous, and incontinent. She exhibited waxy flexibility. In the next five years there were repeated catatonic episodes, which responded to electric shock. During remissions, she was childish, overdependent, and autistic, but, when praised, worked diligently in the ward kitchen as a waitress. Since 1951, no catatonic symptoms have been observed. She is still childish and autistic, and she exhibits swings from mild hypomania to mild depression. She visits her sister on week-ends. Every Monday, she decides the sister doesn't care for her and resolves never to go home again; and every Friday, she accuses the physician of disinterest and asks to be discharged.

For some 10 months, she became increasingly dependent upon the writer. She sought my attention in a hundred childish ways. She insisted upon having her room next to the therapy office, and she jealously watched each patient entering for interview. She fantasied that I kissed them. The slightest rejection resulted in a "thrashing spell," sulking or depression, anger displaced to another patient, or a host of somatic complaints. *Her dependency or transference, however, was more intense to my wife, whom she had never met.* Incessantly she extolled virtues she presumed my wife to have, remarked on the good fortune of my children in having such a mother, identified with them, and begged to be taken into the household—presumably as a maid.

In January 1952, Mary had coryza, and I expressed concern over a cough. She developed a "whoop" with laryngeal stridor. She produced it regularly and almost exclusively when I was with an-



other patient in the therapy office. One physician thought she might have whooping cough. On March 14, another patient began working at my home as a maid. During the lunch hour Mary heard this and realized, though I had repeatedly prepared her, that she was not to be "Mrs. Scheffen's maid." She looked for the other patient in order to attack her, then asked the nurse to allow them to be roommates. She complained bitterly to the attendants about my decision, then went to her room and went to bed. After lunch, I returned to my office and began a therapeutic session with another patient. There was a *loud crying, exactly typical of the hungry infant*, and I found it was coming from Mary's room. The nurse and three attendants later revealed that they had at first shared my belief that someone had smuggled an infant into the ward. When I entered the room, Mary stopped this crying and began deep inspiratory gasps with laryngeal stridor. She was thrashing about in one of the "spells" described previously. I firmly held her face and called her name. She replied, "I'm all right. Leave me alone. I'm just dreaming." I asked her what she was dreaming, but she refused to answer. I confronted her with the fact that she was feeling rejected. At this point, she began to have wheezing typical of bronchial asthma. She said, "No, I don't care." An attendant said, "Don't lie to the doctor, Mary, you do care."

Mary's *wheezing became violent. It was typically asthmatic.* I put my ear to her chest and heard classic sibilant rales. She managed to gasp out, "It's my sister. Last week-end she told me to stop laughing. She said I act like a child. She won't take me home if I act like that. I won't go home. I'll stay right here." At this point she began to sob and produced tears. The wheezing immediately stopped. It lasted the length of the verbatim quotations. Between sobs she said, "Let me up. I have work to do in the dining room." She broke away forcibly and ran out of the room.

In May, she learned I was leaving for another position. She begged me to "adopt" her and take her with us. When I tried to explain that I could not, she had another asthmatic attack and "thrashing spell." She denied previous attacks and no history of them could be obtained. Since I knew I was leaving I resisted the temptation to explore the personality and history in therapeutic sessions.



## SUMMARY

The history of a patient of deficient intelligence who had had a catatonic type of schizophrenic breakdown is recorded. She was extremely dependent and had an intense transference to the physician and his wife. When rejected, she cried with expiratory screams exactly like an infant, and then had a classical attack of bronchial asthma. The asthma immediately disappeared when she began to sob and shed tears. During the attack, she blamed her sister for rejecting her. Later, in a similar situation, she had another attack.

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## INVOLUTIONAL MELANCHOLIA

BY JOSEPH BARNETT, M. D., ARTHUR LEFFORD, M. A., AND  
DONALD PUSHMAN, M. D.

Since the first description of involutional melancholia by Kraepelin, the subject has continued to be in controversy. The description of this syndrome has been expanded and differentiated by numerous writers; its etiology attributed to a variety of factors and its psychopathology variously conjectured. The diversity of attitudes which prevail toward it is eloquently illustrated by a review of the literature.

In this paper, an attempt will be made to clarify and systematize the psychodynamics of the syndrome of involutional melancholia. The psychodynamics of depression, *per se*, have been described and elaborated by Freud,<sup>1</sup> Abraham,<sup>2</sup> and other psychoanalytic writers.<sup>3,4</sup> Some of these writers have discussed and analyzed the dynamics of certain aspects of the involutional depression. Yet because of the heterogeneity of the group referred to clinically as the "involutional psychoses," dynamic understanding of this syndrome has remained obscure. The present discussion will be restricted to a discussion of the typical agitated depressions of this group. The pre-psychotic personality and precipitating factors will be related to the onset and symptomatology of the syndrome.

The classical psychoanalytic approach to depression has emphasized several important predisposing factors, namely: the presence of a strong oral dependent fixation in personality development, the loss of an external object, and the presence of a rigid and severe super-ego. The psychodynamics of depression are explained as due to a basically ambivalent relationship toward objects which supply narcissistic gratifications to the individual. With the threat of loss, or actual loss, of the object, the hostility of the ambivalent relationship is mobilized and directed against the object. However, since the object is no longer externally present, the hostility is directed against the introjected or incorporated representative of the object, this becoming one source of hostility directed against the self. Furthermore, the very expression of hostility in a personality with a severe and punitive super-ego results in considerable guilt, which in turn becomes another source of hostility directed against the self.



## THE PRE-PSYCHOTIC PERSONALITY IN AGITATED DEPRESSIONS

Although analytic theory emphasizes the oral fixation of patients who are predisposed to depression, the writers were impressed by the large number of involuntional melancholiacs who showed anal character traits on clinical examination and whose pre-psychotic personality was predominately anal. Prompted by this impression, the literature was reviewed. It was found that a number of references in the psychoanalytic literature indicate the findings of anal personality traits in depression. Abraham<sup>2</sup> first noted the obsessive-compulsive character formation in the free intervals of manic-depressive patients. Jelliffe and White<sup>5</sup> noted anal obsessive tendencies in involuntional melancholiacs. Gero,<sup>3</sup> in an analysis of an obsessional neurotic, found that with the breakdown of the character defense the patient suffered a strong but temporary melancholic phase. Fenichel<sup>4</sup> states that involuntional melancholia occurs in compulsive characters of an especially rigid nature.

Non-analytic authors have also stressed the importance of traits described as anal compulsive by the psychoanalysts. Brew<sup>6</sup> clearly indicated the rigidity and narrowness of adjustment of the pre-psychotic personality of these patients. Titley,<sup>7</sup> in a critical study, concluded that the general type of personality found to antedate involuntional melancholia has been recognized by the analytic writers as the anal erotic personality. In another paper,<sup>8</sup> he describes a similar pre-psychotic personality in those patients classified as agitated depressions other than the involuntional depressions. Palmer and Sherman,<sup>9</sup> in a broad and well-integrated study, stressed the anal pre-psychotic personality and attempted to relate it to the precipitating factors.

It would appear that the existence of anal character traits in the pre-psychotic personality of the involuntional syndrome is a fact supported by the clinical findings of psychiatrists differing widely in theoretical orientation. It is felt therefore, that a more thorough understanding of the dynamics of the involuntional melancholiac may be approached only through an understanding of the dynamics of this predisposing personality.

## DESCRIPTION OF THE ANAL CHARACTER

The anal character has been described by many analytic authors.<sup>2, 4, 10</sup> The major traits ascribed to this character are orderliness, frugality, and obstinacy. Frugality is a continuation of the



anal habit of retention. Orderliness is an elaboration of the obedience to, and the rebellion against the parental requirements covering the regulation of the excretory functions. Tidiness, punctuality, meticulousness, propriety, all signify a displacement of the compliance to the parental requirements in regard to defecation. The sublimation of retentive attitudes leads to parsimony, miserliness, collecting, and hoarding. The reaction formation to expulsive habits leads to cleanliness, orderliness, organization thoroughness, efficiency, purity, and aversion to contamination and soiling. Sublimations of expulsive habits lead to extreme generosity, extravagance, painting, sculpture and so on.

Analytic authors generally agree that the anal character has its roots in the attitudes developed around the conflicts engendered by toilet training. Rigid attempts at early toilet training are made by the parents—promising harshness and severity for disobedience, and love and narcissistic gratification for obedience. The child, caught between his developing anal erotism and his need for love and narcissistic supplies from the parents, resolves this conflict by the development of a forerunner of the super-ego, called by Ferenczi "sphincter morals," which is later replaced, when the introjected parental authority forms the super-ego.<sup>4</sup>

In the development of the anal character—because of the rigidity of the super-ego's defenses against the instinctual anal needs—certain habitual defensive ego attitudes have been established. Upon the maintenance of these ego attitudes the integrity of the personality depends. The super-ego is now the source of self-esteem and narcissistic gratification formerly supplied by parental figures. It will continue to supply these narcissistic needs as long as the individual continues to live up to its demands. It will withdraw narcissistic supplies when the personality fails to live up to its goals. Thus, the anal character's perception of failure to live up to the rigid goals of the super-ego would lead to a withdrawal of narcissistic supplies by the super-ego. Because of this constant threat, the anal character develops its characteristic rigidity and compulsivity, as described in the foregoing. It is necessary to recognize that the compulsive behavior of the anal character is actually an attempt to accede to the demands of the super-ego. The compulsions are a defense whose aim is to ward off the threat of punishment by, and loss of narcissistic supplies from, the



super-ego. To the anal character, compulsions are necessary to enable him to maintain self-esteem.

#### DECOMPENSATION OF THE ANAL CHARACTER

In order to understand what leads to adaptive failure, consideration must be given to the specific compulsive behavior which has enabled the anal character to live up to his own super-ego demands. Such specific behavior patterns are as multitudinous as the diverse patterns of reaction seen in specific cases of involutional melancholia. It is possible to consider compulsive defense behavior broadly with respect to adjustments to work, interpersonal relationships, sexual adjustments, etc. In a given individual, there may be compulsive attitudes and needs with respect to any or all of these areas. Until the breakdown, the individual has been able successfully to live up to his super-ego's demands with respect to his needs in these areas. He has adapted at a specific compulsive level.

In the involutional period, readjustments become necessary. His character structure, however, demands that he act and behave in a manner no longer physically or socially possible for him. It is not the physiological or social changes *per se* that are crucial in the precipitation of the psychosis. It is rather the unique and personal significance, for the compulsive character, of these changes that precipitates the breakdown. The economy of the compulsive character is precarious. These changes imply his inability to continue his appeasement of the super-ego. Major environmental changes may occur to demonstrate to him his inability to continue his rigid adjustment. However, the unconscious perception of changes of a subtle nature may be the precipitating factor for the decompensation. Should the ego at any time perceive or interpret some event as an inability to appease the super-ego, the anticipatory anxiety of loss of self-esteem occurs to detonate the cycle of depression.

Although the involutional period introduces specific traumata which are of grave danger to the anal character, it is expected that depressive states corresponding to the involutional agitated depressions will be seen in anal personalities before the physiological involution as well as long after it. Thus the descriptive term "involutional" is misleading insofar as it implies a causal relationship between the clinical syndrome and physiological involution.



## PSYCHOPATHOLOGY OF THE AGITATED DEPRESSIONS

The dynamics of the agitated depressions show a marked similarity to the typical dynamics of the reactive depressions. The differences in symptomatology reflect quite naturally the differences that do exist. The agitated depressions are superimposed on an anal character structure whose *raison d'être* has become the appeasement of a rigid, severe super-ego by compulsive character defenses. For this character type, narcissistic supplies are derived from the super-ego, but only as long as the defense mechanisms of the ego continue in the policy of appeasement. When environmental or physiological changes force the ego to perceive itself as unsuccessful in its habitual defense reactions, anxiety intervenes, the ego mechanisms are paralyzed and further prevent fulfillment of compulsive needs, and the depressive cycle begins. The anticipated and feared loss occurs—the super-ego withdraws narcissistic supplies and the hostility inherent in the ambivalent relationship which the ego has with the super-ego is mobilized and directed against the super-ego. Further hostility is directed against the ego.

One sees here the essential dynamic differences between the reactive depression and the agitated depression of the involutional period. The reactive depressive feels a loss of love from an object in the environment; the involutional melancholiac, the withdrawal of love from within the personality. A reactive depressive, as has been seen, directs hostility against a currently incorporated object; the involutional melancholiac against an object incorporated in early childhood. A trait of the anal character which leads to an important similarity in the dynamics is the ambivalence toward the super-ego. This ambivalence is reflected by the contradictory behavior so frequently seen in the compulsive character. It is apparent that in the involutional melancholiac, the super-ego is an ambivalent object, much as is the external object of the reactive depressive.

In both types of depression, there is a loss of narcissistic supply; in the agitated depression, from the super-ego; in the reactive depression, from the external object. Also, in both, depression *per se* is the result of hostility directed inwardly against two functions of the self, i. e., the ego and the super-ego. In the reactive depressions, hostility is directed against the currently incorporated object and against the ego, as the result of guilt over the expression



of hostility. In the agitated depressions, hostility is also directed against the incorporated object, the super-ego, which represents objects incorporated in early life. However, a greater proportion is directed against the ego, as a result of (1) guilt arising from the ego's failure to accede to the super-ego's demands, and (2) guilt over the expression of hostility. Thus, in the agitated depression more self-directed hostility is directed against the ego. The ego is overwhelmed by guilty self-condemnation, which becomes a more marked clinical feature in this type of depression.

Agitation, as an almost constant feature of this type of depression, may similarly be explained on the basis of these dynamics. The personality of the anal individual is such that equilibrium can be maintained as long as the compulsive defense system satisfactorily placates the super-ego. With the perception of failure, severe anticipatory anxiety occurs because of the certainty of loss of love and impending punishment by the super-ego. This anxiety is present both as free-floating anxiety, and as attempts at motor release of anxiety. This inability to bind anxiety for later release is a further manifestation of the limitation and regression of the ego in one of its major functions.

This anticipatory anxiety also accounts for the frequently expressed ideas of hopelessness and futility which appear in the agitated depressions. The overwhelming anxiety severely impairs ego functioning and, therefore, impairs attempts at adaptation. Thus the patient who states, "There is nothing that can be done, I am hopeless," is merely reporting his perception of his ego's incapacity to do anything about the situation.

The refusal of food seen in severe depressions has been clarified by Gero.<sup>3</sup> Food represents gratification of narcissistic needs, as well as hunger, therefore symbolizing self-esteem. Anorexia signifies the denial of love and esteem in severe self-recrimination and is a form of self-punishment.

In conclusion, it is seen that the clinical symptomatology of the agitated depression reflects the dynamics of the personality. From this point of view, the agitated depressions may be considered as the decompensation of the anal character.

#### CASE PRESENTATIONS

Although the clinical symptomatology and the pre-psychotic anal personality of involutional melancholiacs have been noted and



presented by other writers, two cases will be briefly presented to emphasize these features and to correlate the apparent precipitating factors with the dynamics of the personality. Both cases illustrate the decompensation of anal personalities when confronted with the impossibility of maintaining their rigid work patterns.

### *Case 1*

G. J. was a 66-year-old male cabinetmaker, whose pre-psychotic personality was described as honest, sincere, truthful, thrifty, conservative, pessimistic, proud, strong-willed, stubborn, and with a set of high moral standards. He was considered an excellent cabinet maker—exactng, thorough, neat, punctual, impatient, rigid, and persistent in his work.

The onset of illness occurred about eight months prior to his mental hospital admission. At that time he had a heart attack for which he was hospitalized for two months. Following his return home and to work, he suffered another heart attack and was informed that he would be unable to resume his job. Almost immediately, he began to develop anxiety, lost his self-confidence, became seclusive, anorexic, and depressed. Agitation was a marked early feature. He was apathetic, expressed ideas of futility and hopelessness, stating that nothing could help him.

### *Case 2*

M. C. was a 58-year-old married business man whose pre-psychotic personality was described as practical, parsimonious, over-demanding, domineering, persistent, obstinate, inconsiderate, unappreciative, and given to severe temper outbursts. He complied to the strictest letter of Hebrew orthodoxy. Occasionally, he was given to episodes of compulsive generosity, during which he would seek out strangers, buy them meals and provide them with accommodations. His hobby was modeling plastics.

During the two years prior to his mental hospital admission, his business suffered numerous setbacks. He gradually became restless and anxious and worried constantly about his finances. He became progressively depressed and agitated, paced the floor wringing his hands. He expressed ideas of futility and hopelessness, and stated that he was a failure. He insisted that there were discrepancies in his early income tax returns and feared that the authorities were going to punish him.



In both these cases, the anal pre-psychotic personality is unmistakable. In the first case, the precipitating factors involved a physical disability—two heart attacks—which precluded the maintenance of his rigid work adjustment. The patient showed anal character traits of an essentially retentive type which embraced many facets of his personality. His most persistent and marked compulsive system, however, appeared to involve his work situation, which was just the system where re-adaptation along less compulsive lines was indicated because of his heart attacks. Another interesting clinical observation is the appearance of impotence as a purely secondary symptom—apparently the result of withdrawal of libidinal cathexes seen so frequently in depression. In keeping with the dynamics, free-floating anxiety was seen to precede the early depressive elements. This is interpreted as anxiety over the impending loss of narcissistic supplies from the super-ego as a result of the perception of, in this case, an environmentally-produced prohibition preventing maintenance of compulsive defenses.

In the second case, one sees an anal character with an admixture of retentive and expulsive elements. An interesting example of ambivalence toward the super-ego is seen in a parsimonious, miserly individual who has outbursts of compulsive generosity. In this case, no physical precipitant is seen. Whether because of his own diminished productivity or because of economic conditions, he suffered business reverses. This was sufficient to demonstrate his inability to continue in his anal attitudes toward money, at once retentive and expulsive, and this precipitated anxiety, followed by an agitated depression.

These two cases are presented primarily as illustrative material and can be supplemented by many cases seen by the authors and by many cases among those reported by others.

#### SUMMARY

1. The pre-psychotic personality of patients developing agitated depressions is described as the anal-compulsive character.
2. The development and characteristics of the anal character are outlined.
3. The agitated depressions are considered as the decompensation of an anal character.



4. The precipitating factors are considered to be traumata which prevent the maintenance of characteristically rigid ego defenses.

5. A differential comparison is made of the psychodynamics of the reactive and agitated depressions.

6. The psychopathology of the symptoms is related to the prepsychotic personality and its decompensation.

7. Two illustrative cases are presented.

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## CHILDHOOD SCHIZOPHRENIA\*

BY LAURETTA BENDER, M. D.

This discussion of experience at Bellevue Hospital, New York City, with childhood schizophrenia is presented because of the opportunities there to observe a large number of children that have been diagnosed schizophrenic, and because of the research work that it has been possible to do with them. This is not a review of the literature on childhood schizophrenia; but it should be recalled, nevertheless, that historically schizophrenia or dementia præcox has been considered characteristically a puberty psychosis, and its occurrence in childhood before puberty has been considered very rare. However, even Kraepelin<sup>1</sup> is often quoted, (Kanner<sup>2</sup> and Bradley<sup>3</sup>) as having said that in 3.5 per cent of adult schizophrenics clinical signs could be traced back to early childhood.

Bleuler has said: "Schizophrenia is not a puberty psychosis in the strict sense of the word, although in the majority of patients the sickness becomes manifest soon after puberty. With relatively accurate case histories one can trace back the illness to childhood or even to the first year of life in at least 5 per cent of the cases."<sup>4</sup> He also said, "If we observe patients during childhood, they present the same symptoms as those seen in adults."

In this regard, the writer would differ with Bleuler, except to agree that there are some children in whom this is true. We have to expect, however, many different signs and symptoms in schizophrenia in childhood from those in adulthood, just as we expect different signs and symptoms in postencephalitic, neurological and behavior disorders in childhood from those seen in adults. Bleuler further says<sup>4</sup> that the analysis of such youthful patients is much more difficult than that of adults, since we have not had adequate experience with techniques which are suitable for the youthful psychotic.

In the last 20 years, however, techniques have been improved for understanding the child—the child in general, and also the deviate child, including the child with schizophrenia. It was in 1933 that Potter,<sup>5</sup> then a member of the New York State hospital system, defined schizophrenia of childhood and stated it was more common

\*Read at the Bimonthly Conference of the New York State Department of Mental Hygiene at Manhattan State Hospital, Ward's Island, New York 35, N. Y., October 22, 1952.



than generally supposed, especially in institutions for mental defectives. Since then there has raged a controversy in this country as to whether childhood schizophrenia is the same as adult dementia præcox or whether it is a reactive pattern, such as the Adolf Meyer school of psychiatry has taught, reactive in particular to a cold emotional climate in the home during the first two years of the infant's life.

Kanner, of Johns Hopkins, has referred particularly to "early infantile autism"<sup>6</sup> as a response to refrigerator parents who cannot defrost.<sup>7</sup> He distinguishes this condition from Heller's disease, or an infantile dementia which is believed to result from a definite gliosis of the brain. Many workers related to the psychoanalytic schools believe that schizophrenia is dynamically determined like a neurosis, and speak of a withdrawal from reality, especially the disturbing reality of a poor mother-infant relationship (Despert,<sup>8</sup> Mahler<sup>9</sup>).

The most critical problems at the present time are: in the first place, to establish diagnostic criteria specific for childhood schizophrenia (that was what Bleuler implied); and in the second place, to carry on adequate follow-up studies which will determine the course of the childhood disorder into adulthood. For the purpose of further research and study, there are also many other important problems such as the etiological factors; dynamics, both psychological and biological; treatment and prognosis, and many philosophical problems related to human behavior. The first two, however, are the really critical ones at present. To repeat, they are to establish diagnostic criteria specific for childhood schizophrenia; and to follow up children so diagnosed into adulthood to determine the courses of their illnesses and the ways in which they have dealt with them.

It has been possible for me to make some sort of beginning in this direction since I have been working on the children's wards at the Psychiatric Division of Bellevue Hospital since 1934, or for more than 18 years.\* At this time I shall attempt only to give a rather rapid and cursory survey of our follow-up studies as far as they have been completed, in order to show data relative to the incidence and course of childhood schizophrenia as we have seen

\*I have had research support from the 33d Degree Scottish Rite Masons for about eight years, and from the Mental Health Institute of the United States Public Health Service for three years.



them at Bellevue, and evidence concerning the confirmation of the diagnoses made. Second, I shall present our current definition of childhood schizophrenia and a descriptive picture of the development of schizophrenic children, thereby illustrating the diagnostic criteria. The material at this time has been formulated principally as a basis for future study.

The follow-up data have been accumulated largely by the research teams that have worked with me in the past, especially in the last three years with the support of the Mental Health Institute of the United States Public Health Service, a team which consisted of three psychiatrists, two psychologists, a social worker, and a biometrician.†

From 1934 to 1951 inclusive, which is the period these figures cover, 6,500 children have passed through the children's ward at Bellevue. During that time, 626 have been diagnosed as schizophrenic (See Table 1). These children ranged in age from two to 13 years (inclusive). There were only a few in the early years of the puberty period, and, except for two, even those had been diagnosed as schizophrenic before they reached puberty. Of the total, 12 per cent were five years of age or under.

Table 1. Age and Sex Incidence of Schizophrenic Children Observed and Diagnosed on the Children's Ward of Bellevue, 1934-1951 (inclusive)

Age	Boys	Girls	Ratio: B G	Total
2 .....	2	1	2	3
3 .....	11	4	2.7	15
4 .....	18	6	3	24
5 .....	32	12	2.7	34
6 .....	39	20	2	59
7 .....	55	27	2	82
8 .....	82	21	4	103
9 .....	70	11	6.4	91
10 .....	69	23	3	92
11 .....	56	29	2	85
12 .....	18	9	2	37*
13 .....	3	8	0	11*
	455	171	2.66	626

\*The drop in figures after 11 years is a selective factor, due to the admission policy on the ward, which is to accept children of 12 and over only occasionally.

†Alfred M. Freedman, M. D., Raymond Keeler, M. D., Betty Allen Magruder, M. D., Saul Gurevitz, Ph.D., Ilse Goldberg, Ph.D., Alvin E. Grugett, Jr., and William Helme.



Six hundred and twenty-six children out of 6,500, make a 9.5 per cent incidence in this ward group during this period. It is true that in the early years there were very few that were recognized; but in 1950, there were 127 out of a total of 316 children observed, or 40 per cent. This, of course, is an artificial situation, caused by the research programs, which have brought schizophrenic children to Bellevue, and by virtue of which, they have been readmitted frequently so that observation, treatment and follow-up studies could be carried on.

The sex ratio in this total group with schizophrenia is 2.66 times as many boys as girls. The ratio, however, of boys and girls that are observed at Bellevue in all categories is 4.5 times as many boys as girls, so that there is a distinct tendency within the schizophrenic children's group to come nearer to the 1:1 ratio than among the non-schizophrenic children. In boys, the highest incidence was in children of eight and nine, where the ratios were four and six times as many boys as girls; and the highest incidence among girls was seven and 11, where there were only two boys to one girl. (The data are not representative above the age of 11, since the older children are not usually admitted on the children's ward.)

In 1950-51, follow-up studies were made on 350 children who were observed between 1934 and 1946, so that the follow-ups covered from five to 15 years. These were grouped into several categories.

Forty-three children who were diagnosed as schizophrenics between 1938 and 1942 and had ranged in age from four to 13 received metrazol treatment. They were followed up in 1951 when they were in late adolescence or were young adults, ranging from 17 to 26 years of age.

One hundred who were diagnosed schizophrenic between 1943 and 1946, when they were four to 12 years of age, were treated with electric shock. These children were all pre-puberal when the diagnosis was made, and 85 per cent of them in 1951 were in the postpuberty period, ranging from nine to 18 years of age. This group of 100 electric-shock-treated children was reported on to the American Neurological Association meeting in 1947.<sup>10</sup>

There were 50 children who were diagnosed as schizophrenic during the same period, 1934 to 1946, who had not received shock treat-



ment, and 110 children observed during the same period who were not schizophrenic.

The analysis of the first 143 children will be given first, because they are the ones that we know the best, and these were reported at the American Neurological Association meeting in 1952. This was the group of children who received metrazol and electric shock and were followed up in 1951 to determine their present statuses and whether their diagnoses had been confirmed.<sup>11</sup> Studies have not been completed as to the evaluation of the shock treatment as such, although a little information can be given about that. The follow-up studies showed (Table 2) that we were able to get into contact with 120 of these individuals. They range in age as of December 1952 from puberty (11 years) to the late 20's.

Table 2. Follow-up Diagnoses on 143 Children Diagnosed (1938-1946, age 4-14) as Childhood Schizophrenia

Age 1951	Number	Schiz.	Ment. def.	Other type psychosis	Person- sonality disorder	Additional schiz. (research staff Dx.— only available)	No diag- nosis avail- able
9-12 .....	20	7	4	1	1	4	3
13-15 .....	47	26	4	1	2	4	10
16-20 .....	50	21	8	6	3	6	6
21-25 .....	26	15	0	1	4	2	4
Total .....	143	69	16	9	10	16	23

Sixty-nine of these persons were in state hospitals where the medical staffs had diagnosed them as schizophrenic or dementia præcox patients of the typical adult type. An additional 16 were diagnosed mentally defective, but they were chronic inmates in institutions for mental defectives; and the diagnosis was admittedly an administrative one. All of the 16 were re-examined by the Bellevue research staff in 1951, which was not the same staff that made the original diagnosis, but was a special research group, and all were diagnosed as schizophrenia.

Nine were in state mental institutions, having been diagnosed as having some other form of psychosis, and 10 others as having some form of personality disorder such as psychopathic personality or a personality behavior disorder. Of these 19, 10 were re-examined by the Bellevue research staff; six were considered schizophrenic,



four as having some other psychosis or a personality disorder. In 16 other cases the follow-up diagnosis was made officially only by our own research staff, although several of these persons were recognized also by various authorities such as draft boards, schools or social agencies, as frankly schizophrenic. In the last 23 cases, we have still not been able to confirm the diagnoses, although, since this report was made in the spring of 1952, there have been three others accounted for, with their diagnoses confirmed. Several are in the community and un-co-operative with the follow-up study, although regarded by the family, or often by a supervising agency, as disturbed, or showing serious symptoms.

Therefore, by the most severe criteria—that is, recorded diagnoses by another medical staff—66 per cent of the 104 patients later evaluated by state hospital staffs were found to be adolescent or adult schizophrenics.

Diagnoses have been confirmed by our own staff in another group of 38,\* bringing the confirmation to 87 per cent (spring 1952) or to 89 per cent (December 1952); and the remaining 13 per cent are not proved not to be schizophrenic.

To give data about their adjustment, about two-thirds of the child schizophrenics have required state hospital care subsequent to their care in Bellevue. One-half of them went directly from Bellevue to some state institution, and one-third of the total group have remained continuously, and are still, in state hospitals or other state institutions.

At the beginning, 50 per cent remained in the community. Of these, some went back into the hospitals, and of those in the hospitals, some returned to the community, so that 50 per cent are now again in the community. Twenty-five per cent of the 50 now in the community are showing a fair-to-good adjustment. Consequently, one may prognosticate that where the diagnosis of childhood schizophrenia is made before puberty, a 50 per cent favorable, though often somewhat limited, adjustment may be anticipated.

The 50 children who were diagnosed schizophrenic during the period under study but who did not receive electric shock have been found the most difficult group to follow up. It was expected to have a control group of 100, but the research staff has had to be

\*These 38 include the 16 patients seen in follow-up by the research staff only, plus the 22 considered schizophrenic by the research staff but otherwise classified by other staffs.



satisfied so far with 50 although it had proved possible to follow up the 143 in the shock-treated groups. The reasons that the control group proved elusive were in part the same reasons for their not having received electric shock treatment. These children had not received it for the following reasons: 10 per cent were diagnosed (1934-38) before the shock treatment program started. At that time, the diagnosis was made only on the most severe cases. Of these most severe cases, another 10 per cent were considered unsuitable for treatment because they were too paranoid and uncooperative, especially around the pre-puberal period; 15 per cent were considered mild cases and possibly able to get along without treatment. There has always been great resistance to treating cases with shock where anyone has any doubt about the diagnosis.

On the other hand, 65 per cent were recommended for treatment, but their parents refused permission. It is among this largest proportion that there has been the poorest response to later attempts to obtain the necessary co-operation for follow-up study.

Confirmation of the diagnoses within this group of 50 non-shock-treated individuals has been made by other hospital medical staffs. Of the 42 patients who were evaluated later, 28 were diagnosed schizophrenic, eight were considered mental defectives (two with psychosis associated), three were diagnosed psychopathic personalities, and three have other diagnoses. Eight, although the research staff knows their whereabouts, have not been available for examination.

Of the 28 diagnoses that were confirmed by outside staffs, the Bellevue research staff saw nine patients, and agreed with the diagnoses, but it was not possible to see any of the other individuals.

Interestingly enough, the course of these 50 non-shock-treated cases is in many ways similar to the other 143 shock-treated cases, except for some differences the writer would like to point out. Two-thirds of the non-shock-treated group were subsequently sent to state hospitals. In most instances, they did not go immediately from Bellevue to the state hospital, for the same reasons that they did not receive treatment: lack of co-operation on the part of the parents; disagreement between the parents and the Bellevue recommendations; or, maybe, it was Bellevue that did not co-operate. One-third of the group remained chronically in state hospitals and were reported to be emotionally flattened with minimal adjustment. Five were definitely deteriorated.



These are practically the same proportions as for the 143 shock-treated individuals: that is, two-thirds were at some time or other in the state hospital and one-third were still in the state hospital in a poor condition. The patients who were not treated, however, did not go to the state hospitals until later. Another difference is that among these non-shock-treated patients it was possible to learn of only two who are presumably, from hearsay, making fair-to-good adjustments, whereas about one-fourth of the 143 shock-treated patients are making fair-to-good adjustments, and some are making good adjustments.

There were also 120 non-schizophrenic children that were followed up because they represented problems other than schizophrenia that interested the research workers, and that had had papers written about them. These children were followed up in part to determine the importance of their specific psychopathology\* and also to give us control material for the schizophrenic studies.

These children were reported under certain descriptive categories. There were papers on aggression in children by Schilder and myself,<sup>12</sup> and 10 of these children were followed up; and on children with suicidal tendencies,<sup>13</sup> 16 of whom were followed up; and one on children with homicidal tendencies or who had actually committed homicide,<sup>14</sup> by Curran and myself, 15 of whom were followed up.

There was a paper on fire-setters in children<sup>15</sup> by Yarnell, and 13 of these were followed up. There was one on children with hallucinations<sup>16</sup> by the writer and Lipkowitz, and one on imaginary companions<sup>17</sup> by the writer and Vogel. In each of these groups, 12 were followed up. There was a paper on impulses and compulsions<sup>18</sup> by Schilder and the writer, one on obsessions<sup>19</sup> by Berman, one on sexual confusion and homosexual tendencies in children<sup>20</sup> by Paster and the writer, and one on children who had sexual activities with adults by Blau and the writer.<sup>21\*\*</sup>

In all, there was a total of 120 children who were not considered to be schizophrenic when they were studied under these various

\*These papers and the follow-up studies are being published in two books: *Aggression, Hostility and Anxiety in Children*, and *Dynamic Psychotherapy of Childhood*, published by Charles C. Thomas, 1953 and 1954.

\*\*The follow-up study of these children with atypical sexual experiences has been reported by the writer and Grugett (Ref. 22).



headings; 25 per cent of these turned out to be schizophrenics in the follow-up study in 1951.

In this group, the ones most likely to be schizophrenics were those with pre-puberty psychosexual confusion or homosexual trends, preoccupations and problems; those who had impulsions, compulsions, and obsessions; and those with suicidal and death preoccupations.

Interestingly enough, children with hallucinations and imaginary companions, were least likely to be schizophrenic; and, if they were, they had excellent prognoses.

Out of this group of non-schizophrenic children, 30 have been selected-controls for 30 of the schizophrenic. A statistical analysis has been made of the diagnostic criteria, comparing the two groups, showing statistically (material which is not presented here\*) a definite validity of the diagnosis of schizophrenia as against the non-schizophrenic problem child. In this study only those symptoms were used which were evident when the child was first seen and before he received shock treatment, and which were recognized under conditions which were different from the present, inasmuch as we did not then have the understanding of the symptomatology we now have.

The data were found to be confirmed, especially in regard to those symptoms which can be called nearest to the biological phenomena of the individual, such as vasovegetative, motility and form-perception disturbances, in contrast to those which might be called psychological reactions or related to psychogenic factors.<sup>11</sup>

From this introductory survey of the studies we have been making in connection with the life courses of children diagnosed as schizophrenic, we may pass on to the second area mentioned in the beginning: the question of diagnostic criteria. Bleuler said that the difficulties lay in finding techniques suitable for analyzing childhood psychoses and so suitable for evaluating observations and determining therefrom the diagnostic criteria.

In the course of recent years many new areas have been added to our experience, areas which have made it possible to develop new diagnostic techniques, and some of these will be mentioned in passing.

1. We have understood more about motility patterns in children, how a motility pattern develops and what it means in terms

\*To be published: Bender and Helme (see Ref. 37).



of neurological integration, and deviations and their significance, including impulse disorders. These are things that have come particularly from the experience and teachings of Schilder.<sup>23</sup>

2. We have learned about body image concepts or the child's developing concept of its own body as it functions in the social and physical world, and its relation to the motility problems. This, too, was Paul Schilder's concept.<sup>24</sup>

3. We have learned much about maturational patterns, especially as they are derivations of behavior from embryological patterns. This is the work of Gesell,<sup>25</sup> and this, particularly, has contributed in the last two or three years to my personal understanding of childhood schizophrenia.

4. We have acquired increasing knowledge about perceptual motor integration by patterns and by the use of projective techniques for the study of such patterns, their maturation and deviations. These are the contributions of the Gestalt school of psychology. A visual motor gestalt test which I have developed has been useful in our hands.<sup>26</sup>

We have learned more about the dynamics of personality development and its deviation, including such phenomena as identification, introjection, ego boundaries, reality testing, and fantasy formation. This has come especially from psychoanalytic contributions concerning children, genetic psychology, and ego psychology. (See especially Melanie Klein.<sup>27</sup>)

We have learned more about anxiety in infancy and defense mechanisms with secondary neurotic symptomatology. In this regard, one is reminded of the more recent work on pseudoneurotic schizophrenia in adults which throws considerable light on the problems we also see in children. (Hoch and Polatin<sup>28</sup>.)

With the armamentarium which can come from these new points of view and new techniques, we can approach the problem of deviate-child behavior and analyze our data in the very way that Bleuler complained could not be done before. It is as a result of the background of this material that I have come to the formulation of schizophrenia with which my name has been associated.

Again it would be well to give you a little history, as it will, perhaps, make a little clearer what we have arrived at.

In 1942, childhood schizophrenia was defined<sup>29</sup> by me and our group at Bellevue as a clinical entity occurring before the age of 11, which revealed pathology in behavior at every level and in



every area of integration or patterning within the functioning of the central nervous system. The vegetative, motor, perceptual, intellectual, emotional and social areas were all involved. The important thing in making a diagnosis of childhood schizophrenia is to realize that one symptom does not make a schizophrenic child; the typical symptomatology must pervade in every area of functioning.

Furthermore, this behavior pathology disturbs the pattern of every functioning field in a characteristic way. It was further defined at that time as a form of encephalopathy occurring at different points in the developmental curve and interfering with the normal developmental pattern of the biological unit and of the social personality in a characteristic way, causing anxiety to which the child must react, according to his own capacity, with neurotic defense mechanisms.

In 1947, the deviation in behavior was studied in different areas such as vasovegetative, homeostatic function, and growth areas; motility and motor development; perception; thought; language; symbol formation; and specific psychological problems at the different age levels of schizophrenic children.<sup>30</sup>

In 1949, this definition was modified by adding the concept of plasticity.<sup>31</sup> That is to say, a specific pattern of disturbed behavior in each area of function is best understood if one considers a high degree of plasticity as the primary feature of the schizophrenic process in the child. With this one then can best understand most of the symptomatology of the schizophrenic child and the wide variety of clinical pictures in different schizophrenic children.

Thus, some schizophrenic children are regressed, retarded, fixated, blocked, inhibited, mute, autistic, withdrawn, physically asthenic, puny or under-developed, unsocial, unable to relate, concretistic in their thinking; but there are other schizophrenic children who are just the opposite. They are precocious, develop too fast, have an exaggerated intellectual brilliance, are overactive and cannot be suppressed in their activity. They have precocious language development, are highly articulate, and often show special gifts, especially in language, the graphic arts and dancing, and in their insight into psychological problems. They tend to overidentify in any group and they relate too well. These children call forth strong counter-transferences from adults. They are excessively abstract in their thinking. Some children go



through phases of these extremes of behavior, while most of them show mixtures of the tendencies, although one or the other may predominate. This plasticity can best account for the variety of pictures which I have diagnosed as schizophrenic and which, as my figures show, we have been able to confirm as subsequently being adult dementia præcox.

The outstanding psychological problems of the schizophrenic child have to do with body functions, motility, body image, identity, and object relationship, all of which are distorted by the schizophrenic process, although all of them represent exaggeration of the problems of normal children during development. The resulting anxiety is the most apparent sign of suffering and is a true danger sign of the threat of disintegration of a personality. This anxiety tends to express itself through all of the schizophrenic disturbances and also in neurotic symptom formation. The latter may be the presenting symptom. Experience has led to the conclusion that any severe psychoneurotic disorder in a child before puberty, whether it is obsessive-compulsive, so-called hysterical or simply severe anxiety, is a reactive response to a deeper, inherent threatening disorder, most often schizophrenia, although possibly some other organic brain disorder.

In the last two or three years, the writer's concept<sup>32</sup> of childhood schizophrenia has been greatly influenced by the work of Arnold Gesell, especially by his book, *Embryology of Behavior*, which appeared in 1945.<sup>25</sup> On the basis of his observations of fetal infants he maintains that all behavior evolves from five basic physiologic functions. These functions are the prerequisites of all future behavior. They are classified as follows: (1) homeostatic mechanisms; (2) state of consciousness, sleep and waking patterns; (3) respiration patterns; (4) muscle tone; and (5) tonic neck-reflex attitudes which underlie all motor behavior.

For example, Gesell describes the early fetal infant—that is, of 28 to 30 weeks postconception—as torporous. The torpor is fluctuant and shallow. He neither sleeps, nor is he awake. He is flaccid with a minimal uneven tone. His breathing is shallow, irregular, and out of tempo with his needs. Postural movements are sporadic. He shows an attitude of accommodation to the rounded walls of the uterus, an occasional impulse to elevate an arm into a floating tonic neck reflex posture, stretching, relaxing, and arresting movements into occasional catatonic postures. Response



to sensory stimuli is evidenced by the fingers flexing on the touch of a rod to the palm of the hand and waves of vibratory activity in response to sound. The most conspicuous behavior trait is ever-recurring torpor.

Gesell goes on at each level and describes the fetal infant in the next four weeks as a little less moluscous, more compact, and with some tonic neck reflex movements with arms floating and head turning.

The late stage fetal infant shows some homeostatic "wisdom," an effort at rhythm of activity and rest, and some knack of sleeping. The head rotates in supine position, and the whole body takes on spontaneous movements of the tonic neck reflex type.

In the newborn, breathing is irregular and the pulse variable. The intestinal tract is hyperactive, and there is poor control of body temperature. At one month the infant is expected to have better homeostatic control, more compact tone; it braces itself to be lifted, responds to social attention, gets a pattern of sleep, wakefulness, respiratory rhythm, feeding and elimination. Tonic neck reflex motility occurs as a part of the startle reaction, but gives way to more intricate behavior, involving grasping, sucking, turning of the head to stimuli, etc.

When one studies the schizophrenic infant, which we have done so far largely from the careful biographical notes of intelligent mothers and from pictures—and more recently some of the younger ones personally; the research staff has been seeing such children, one of them under a year, some between one and two years, a number between two and three years—we find that the schizophrenic infant retains all of the early embryological features which have been outlined for the fetal infant by Gesell. Even as the child continues to develop somatically, intellectually, and also in his neurological integration, he carries along with him these embryological characteristics of primitive homeostatic control, primitive patterns of sleep and wakefulness with waning states of consciousness, primitive tone, and a tonic neck-reflex dominance of all motility.

Anxiety is these children's first response and may be unremitting from the first day of life, or, of course, it may appear at any time later. Secondary neurotic habit patterns may be evident from the early months and are evidence, of course, of the struggle for ego maturity and the struggle for health. On the other hand, the in-



fant may succumb to a more or less completely unpatterned torporous state, with a retarded ego and intellect.

There is one other factor in relation to primitivity that must be appreciated. If there is a retardation of the personality of the total biological organism—thinking of personality as a biological unit—to a primitive level, then the concept of plasticity applies especially. Anything that is primitive may not only be retarded but also may have unlimited capacity for development. It is this very primitivity which makes it possible for some children to overshoot in their development, to become precocious, gifted, and overactive, and to show all of the various over-responses which already have been described. And, of course, we have seen all sorts of combinations of these patterns.

The secondary psychological problems which develop in the schizophrenic child have to do with difficulties in the body image concept, difficulties in object identification, or in identifying himself with reality, and difficulties in handling his anxiety. These become the three major problems for the child.

The full description of all of these problems will not be gone into at this time, and the writer finds it easiest to be articulate about the body image problems. The schizophrenic child's body has not acquired homeostatic wisdom, and his nutritional and eliminative patterns may not be readily established. He may be a feeding and toilet-training problem. He tends to have oral and anal fixations. His pulse and temperature control are not adequate. His vascular system is labile. His development curves are uneven. He is subject to the so-called allergies, colics, coeliac disease, recurring respiratory illnesses, gastro-intestinal illnesses, skin disorders: that is, all of the psychosomatic disorders.

Such a child becomes hypochondriacal and aware of his internal organs and functions. His sleep patterns are not well established. He is restless at night, subject to night activities, anxieties, nightmares, tantrums. He dreams and fantasies about sleeping, waking, fainting, dying, disappearing and having blackouts. His respiratory patterns are not regulated. This leads further to subjection to more of the things just described, these disturbed states of consciousness, anxieties, preoccupations about death. Also immaturities in speech, language and thought may be related problems.

A normal body tone is never acquired. The child's physical contact with the objective world is not distinct. He and it tend to



melt into each other. From this arises, some of the body boundary problems or ego boundary problems, and the fear of incorporating or being incorporated. This, of course, is the psychoanalytic material which has been known for some time. The schizophrenic child tries to escape from gravity, often by climbing high, whirling, running away, darting, and what not. Or else he is fearful that he will escape from gravity and fly off into space.

The tonic neck-reflex impulses dominate his motility so that he is always subject to impulses to whirl or go out into space, or else he must resist these. He has difficulties in object identification, and has anxiety obviously derived from all of these problems, together with other problems which are as yet too difficult to formulate.

Consequently, our present formulation of a definition for childhood schizophrenia is a developmental lag of the biological processes from which subsequent behavior evolves by maturation at an embryological level, characterized by an embryonic plasticity, leading to anxiety and, secondarily, to neurotic defense mechanisms.

In regard to the question of etiology, it has already been mentioned that there is a controversy as to whether childhood schizophrenia is a reaction to inadequate parent-child relationship or if it is akin to adult schizophrenia or dementia præcox. The writer has been tremendously impressed with the heredity factor. The data on heredity have not been fully collected or analyzed, but even the incomplete material has important implications. Of 143 schizophrenic children we followed (the groups that received metrazol and electric shock treatment), 57, or 40 per cent, are known at the present time to have one parent with a definite or suggested diagnosis of schizophrenia in the records; 15, or 10 per cent, are known to have both parents with such a recorded or suggested diagnosis; 11 have siblings under treatment for schizophrenia. In the past three years, several pairs of identical twin children in which both children were schizophrenic have been observed at Bellevue. In these respects our clinical experiences and impressions agree with the conclusion of Kallman's studies on the genetic theory of schizophrenia.<sup>33</sup>

The etiological factor which is most important in precipitating the schizophrenic illness is a physiological crisis, such as birth, es-



pecially with damage such as anoxia; severe illness or accidents; and the pre-puberal and puberal, crises.

The parent-child relationship or the emotional climate of the family, especially in the first two years, will help determine the defense mechanisms, the ability to handle regressive tendencies, impulses, anxiety, etc. In other words, no child can develop schizophrenia unless predisposed by heredity; the psychosis is precipitated by a physiological crisis; the pattern of the psychosis and its defense mechanisms are determined by environmental and psychological factors.

Now as to the question of treatment; with the definition of maturational lag plus plasticity, plus anxiety, plus defense mechanisms, the treatment approach may be more clearly defined. This will mean that therapy which aims to break down neurotic mechanisms and give insight into neurotic dynamics, is contraindicated.

Treatment should, if this definition of childhood schizophrenia holds, aim, in the first place, at the stimulation of maturation; second, at the patterning of plasticity; third, at the control or relief of anxiety; and, fourth, at the strengthening of defense mechanisms.

Therefore, treatment may include shock treatment which seems to be stimulating to maturation and to the patterning of plasticity. We have considerable evidence from clinical follow-up studies, from EEG reports, Wetzel grids and from other areas, in this direction.

Drugs may be used to help the child control his impulses, to pattern plasticity, and to stimulate maturation.

Psychotherapy should certainly be used, but it should be of the kind which stimulates neurotic formation and does not break it down—or rather helps the child to develop a useful or social form of neurotic formation.<sup>34</sup>

Group experiences away from the family conflict, at least for a period, may be both stimulating to maturation and helpful to the child.

Treatment of the parents,<sup>35</sup> especially in groups as we have often done at Bellevue, will help them understand their problems.

One of the most interesting treatment experiences which we have had, and which has shed a great deal of light both theoretically and practically on the situation, has been with schizophrenic children who also had reading disabilities.<sup>36</sup> Our concept of a reading disa-



bility is that it, too, is a maturational lag in the specific areas of language. We know what to do about reading disabilities. They call for tutoring in a specific way by a specially trained tutor who can also relate to the student. Consequently, when we have had schizophrenic children who had reading disabilities and we gave them specific tutoring for their reading disabilities, we not only cured or improved them in relation to the reading disability but we also improved them dramatically in relation to schizophrenia.

This, therefore, leads to the possibility of our studying schizophrenic children for other areas of specific maturational lags, and treating those lags specifically, through, of course, a person who relates to the child—not to interpret dynamics or to break down neurotic patterns—but to help with the specific disability and with the general maturation problem which is the schizophrenic disorder.

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## EDITORIAL COMMENT

### "ALL HIS FANCY"

"It's all his fancy that," said the Gryphon of the Mock Turtle, "he hasn't got no sorrow, you know." But the Mock Turtle sat "sad and lonely on a little ledge of rock," his "large eyes full of tears." He was "sighing as if his heart would break."

No one would pretend that this sort of thing ever completely described the popular attitude, still less the general medical attitude, toward mental and emotional illness. But casual readings or conversations on this topic readily reveal that it still remains an element in some popular and, one regrets to say, some medical thinking as well—particularly in regard to those minor mental illnesses which do not generally lead to hospitalization. The term imagination is still used to describe the source and/or cause of many neurotic symptoms, and it is still believed, even by some medical men, that cure is effected by the patient realizing that the cause is not organic and by either stopping the process of "worrying about it," or even more simply by "forgetting it." Would that the cure were so simple, but the actual experience of specialist after specialist, and general practitioner after general practitioner, proves that it is not.

This point is raised here because there is reason to wonder if our mental hygiene educational campaigns and lectures should not strengthen their efforts to make it plain to the public and all medical personnel concerned that mental disorder is—in every sense of the word—real. It is a matter brought to mind by, of all things, a textbook of cardiology in which a cardiologist discusses a common "heart neurosis" in such enlightened fashion as to bring sharply to professional attention just how uncommon such discussion is.

The cardiologist is Lt. Col. Weldon J. Walker (MC) U. S. A., contributor of a chapter on neurocirculatory asthenia to a new medical text, *Clinical Cardiology*,\* of which Franklin C. Massey, M. D., is editor. Colonel Walker emphatically does not belong to

\**Clinical Cardiology*. Franklin C. Massey, M. D., editor. Williams & Wilkins. Baltimore. 1953. (Chapter on "Neurocirculatory Asthenia" arranged and reprinted by *Current Medical Digest*, May 1953.)



the school of those who exhaust the repertoire of examinations and tests and then tell the patient triumphantly: "You will be very glad to know that there is nothing whatever wrong with your heart; I have given you a most careful and thorough examination, and your heart is in perfect condition; there is nothing serious wrong with you; you can stop worrying." But the patient has symptoms of exhaustion after slight effort, breathlessness, palpitation, faintness, throbbing, left-side thoracic pain and syncope. He knows very well, whatever the doctor says, that there is something serious (in the sense of painful, frightening and crippling) wrong with him—and so, of course, do we. And so does Colonel Walker, who believes not only in telling him so but in telling him what it is. And, "It is important," he writes, "that the diagnosis be made at the time of the first examination."

Here is a cardiologist who looks for the symptoms of neurosis (or psychosomatic disturbance) at the same time and in the same way that he looks for the symptoms of organic heart disorder in obtaining a medical and personal history and making a complete physical examination. If he finds the characteristic symptoms of neurotic disturbance, he tells the patient so, and tells him promptly—lest the patient feel that the diagnosis of the one has been made merely by exclusion of the other (and candor would compel most of us to admit with some embarrassment that we have seen diagnoses made just that way). "It is important," says Colonel Walker, "that a positive diagnosis be made before doing the laboratory studies—the physician thus shows confidence in his diagnosis, and as each normal laboratory study is reported, the patient's confidence in the physician is increased. If he orders extensive laboratory studies without telling the patient he expects them to be negative, with each normal finding, the patient's esteem for the physician will drop. The patient assumes the tests were ordered to 'find out what was wrong.' When the physician finally tells the patient his symptoms are due to nervous factors, it appears he is saying this because he has been unable to find anything abnormal with the tests. To the patient, it looks like an alibi, his confidence in the doctor is shaken and the usual story is for him to consult a different physician who, too often, 'does some different tests.'"

Here is an example of an explanation to a patient: "Mr. Jones, after a thorough examination I do not believe you have any serious heart disease, although you have suffered from distressing chest



pain and are naturally concerned about it. The pounding and skipping of your heart, I believe, results from a nervous reaction rather than from disease in your heart. For instance, if you walked down a dark alley at night and a masked bandit suddenly stuck a gun in your ribs, I am sure your heart would beat very fast and hard—not because it was bad, but in response to the nerve impulse that went out because of the fear you were experiencing. Your breath would also come short and fast and your hands would be wet and shaking as they were when you came into the office. Prolonged worry, tension, anger or anxiety can produce the same nervous impulse as intense fear. That this is probably a factor in your case is suggested by the appearance of your symptoms shortly after the arrival of the new foreman with whom you are having trouble. The pain beneath your left nipple probably results from forceful beating of your heart against the chest wall, perhaps from spasms in your muscles of breathing. You are afraid that your heart is bad, and as a double check I suggest we get an electrocardiogram, chest x-ray, blood test and urinalysis as a part of a complete medical evaluation. I expect they will be normal and even if they aren't, I am sure most of your symptoms result from nervous causes since no form of heart trouble can completely explain your symptoms while a tension state readily can.'"

This is eminently reasonable, and ought, one thinks, to be convincing. It ought, for one thing, to prepare the patient for the psychotherapy Colonel Walker thereupon recommends that the doctor give, for he remarks, "it is obvious that no conceivable growth of psychiatry will provide care for all these patients [his estimate is that between one-third and two-thirds of patients who consult physicians have psychological disorders]. Neither is it desirable. It is apparent that each of us must become 'minor psychiatrists' and treat the less severe cases and refer the major ones to experts in the field." As procedures the "minor psychiatrist" may employ, he lists such important matters as acceptance, support, understanding, environmental manipulation, release of emotions, explanation, reassurance, suggestion, persuasion, desensitization and re-education.

Most important of all, the specializing psychiatrist himself may think, Colonel Walker recognizes the patient's psychological difficulty as real. There is a world of difference between explaining to Mr. Jones the psychological source of the difficulties that he



finds are so frightening and crippling, and telling him, "There is nothing whatever the matter with you"—with its implication, "You are certainly a jackass, Mr. Jones."

It seems likely that we have not yet laid enough stress in mental hygiene efforts on the fact that it is unenlightened, fruitless, and possibly even sadistic, to belittle the mental or psychosomatic patient. Colonel Walker suggests that the physician who lacks respect for the psychosomatic or neurotic patient, perhaps thinking the poor fellow is simply made of "poor stuff" and that efforts to help will be wasted, should study his own psychosomatic reactions: "Such a physician's viewpoint may change if he will make a careful assay of his antecedent emotions the next time he experiences a headache, pounding of the heart, insomnia, wet sweaty palms, or abdominal pain, especially if he has eaten when extremely angry. After personally recognizing the relationship between one's own emotions and some of these manifestations, it is surprisingly easier to view them as the normal physiology of emotional expression."

It leads one to wonder if, with all our efforts at public and medical education, we have succeeded in stressing sufficiently the bitter realities of suffering and need for treatment of patients in whom organic pathology does not exist or is not demonstrable. The illustrations Colonel Walker gives are few and sketchy: They could be expanded encyclopedically. It should be possible to give insight to anybody who has ever had a nightmare as to the reality of hallucinations; to make anybody who ever, as a child, stood helpless and trembling with fear, feel the reality of a paralyzing anxiety reaction; or to make any medical student, nauseated by a dissecting room, comprehend the effect of environmental or psychological factors on the gastro-intestinal system. But one suspects that Frank Fay and James Stewart in *Harvey*, through converse with a pleasant (and somewhat exceptional) hallucination, did more to give general insight into the reality of this common—and most often distressing—phenomenon than all our educational endeavors. And the however inaccurate term "battle fatigue," as representing the unbearable intensification of efforts, tensions and stresses that everybody can feel he has experienced himself, has helped, one may believe, general understanding of the reality of neurotic and psychosomatic phenomena.

It should not be impossible eventually to convey generally the idea and the feeling that even in dealing with such a thing as hypo-



chondriasis, physicians are dealing with a reality that calls for respectful recognition and understanding by the physician and that may call for serious psychiatric treatment. To adapt the text for nursery school, one does not accept the hypochondriac's belief that he has cancer, "heart trouble," or "weak lungs"; but one does accept the reality of his belief, the reality of the fear, guilt and anxiety behind that belief, and the need of psychotherapy, not placebos, to restore a panicky patient's healthy functioning. World War II has supported evidence from World War I that even such calculated obstructiveness as malingering has psychological bases in reality and represents a mental condition calling for psychiatric, as well as, or maybe instead of, disciplinary action.

What is of concern here, however, is less the soundness of the psychiatric principles presented in *Clinical Cardiology* than the place and purpose of their presentation. The place is a textbook addressed to non-psychiatric specialists and general practitioners; the purpose is to stress, from a non-psychiatric point of view, the extent of the psychological disorders encountered by cardiologist and general practitioner; and to outline diagnostic criteria and treatment for a specific psychological disorder which affects the functioning of the heart.

Neurocirculatory asthenia is discussed like any other condition affecting the heart; its differential diagnosis is outlined; its treatment is summarized. The patient is told what is wrong—in non-invidious terms. He is recognized as a sick man, which is true, not as poor stuff which is not necessarily true. Furthermore, treatment needs and methods are then set forth.

With the general principles and most of the specific recommendations set down for treatment, the specialist in psychiatry will find little to disagree. There would certainly be some to take issue with the suggestion that the patient be asked to *write* a brief life story the *second or third* visit, as by no means the best procedure. But: "*The physician's entire attitude should be concerned with understanding, not judging the patient.*" He need not determine what is 'right' or 'wrong,' 'good' or 'bad.' It is not the physician's task to dig out confessions, or to discuss sexual experiences prematurely. He should create an atmosphere of trust and confidence into which the patient will spontaneously bring his sensitive, anxiety-laden experiences, memories and fantasies. . . . Reassurance is more effective when offered sparingly and thoughtfully, rather



than frequently and glibly," These are the basic principles of sound psychiatry, and one may believe that they have been observed without exception by all the great psychotherapists. It might be difficult to find, in texts intended for the training of psychiatrists themselves, a better statement of the discipline's philosophy of psychotherapy.

Practically, one may entertain doubts of these proposals. Perhaps our cardiology text presents an ideal, rather than a practical program. Besides the author's estimate that from one-third to two-thirds of all patients who consult physicians suffer from psychological illness (and the estimate commonly seen is nearer the higher figure), he notes that neurocirculatory asthenia alone has been "estimated as the sole disability in from 10 to 50 per cent of patients who visit cardiologists." One wonders what proportion of general practitioners and cardiologists, assuming the latter do the psychotherapy for their own patients, are fitted by training, temperament and sense of responsibility for the role of "minor psychiatrists" that the author envisions—there are psychiatrists themselves who are not. One wonders how many would have the time required for even simple brief psychotherapy—there are enough practitioners now who give the impression that only a combination of cigarettes and hypomania enables them to cope with the overloaded practices they maintain. And one wonders what program of medical school and postgraduate psychiatric education could be devised to make up for these deficiencies. Finally, psychiatry and psychosomatic medicine are severely enough pressed now; could they handle the burden if practitioners everywhere began to pass on to "experts in the field" the "major" cases which proved too much for "minor psychiatrists"? There is reason to think that these would be no small fraction. But this discussion is less concerned with what look like enormous practical difficulties in the future than with this present honest and enlightened presentation to general medical people and to specialists in another field of an important psychiatric problem. It would be a tremendous stride, psychiatrically and medically, if practitioners everywhere were merely to recognize the problem, endeavor to diagnose emotional disease as carefully as physical, and explain it to its victims in non-invidious terms. And such terms often suggest themselves readily: Few patients' acquaintances are likely to jeer at such recognized diagnostic descriptions as "neurocirculatory asthenia,"



"effort syndrome" or "Da Costa's syndrome"—or, in another than the cardiac field, at "spontaneous hypoglycemia" or "cryptogenic hyperinsulinism." Or where non-derogatory medical terms do not readily suggest themselves, a patient may willingly accept the reasonable attribution of his tension, insomnia and lack of appetite to home conflict between his wife and mother, tension over his job, or some other reality factor.

The first consideration in this discussion of the diagnosis of emotional disorder has, thus, been presented as respectful consideration of the patient. Aside from reluctant school children, there is little malingering in civilian medical practice; the person who fantasies an illness as an excuse to stay away from work is likely to keep as far away as possible from a doctor. The vast majority of those who seek medical attention feel ill or think they have good reason to believe they are ill. Whether the illness is emotional or physical, psychiatrists will agree with Colonel Walker that the most important element in the attitude of the physician consulted is "*respect* for the patient." And respect for the patient does not include telling the victim of emotionality, "There's nothing the matter with you, [and expressed, if unspoken] you poor fool." One can as readily say, "This attack (or condition) is caused by worry (or tension, or anxiety, or sorrow). It is distressing, but we can take care of it; this and that are what I want you to do about it." Such respectful honesty, one might maintain, is the due of the hypochondriac, rather than consent by silence to his belief in non-existent physical illness; it is certainly no worse therapy to explain to such a person that his fears are brought on by anxiety than to encourage his delusions; the explanation will not cure, but neither will sugar pills nor laparotomies.

That mental disturbance, great or small, is nobody's "fancy" but should be recognized in matter-of-fact fashion as illness, referred to as such, and treated as such, is one of those self-evident, elementary, simple propositions that one takes for granted—and blithely disregards. The physician's happy tendency of pooh-pooing patients' complaints in the absence of physical findings—rather than diagnosing and explaining minor psychosomatic disturbances—is one of the cornerstones in the structure of non-medical quackery and charlatanry. If a patient does not turn from the doctor "who doesn't know what is the matter" with him to another doctor who



will "make some different tests," he may turn to the quack who pretends to know all about his difficulties. Greater practice of realism in medical diagnoses should deprive the quacks and cultists of much revenue and so contribute to general public health as well as to general mental health.

Perhaps it would be well to provide a little more backbone here as evidence that the fellow who diagnoses "all his fancy that" is something more than a straw bogey clothed in medical trappings. Consider hysteria, a disorder named for the Greek word for the uterus and once mistakenly supposed to be confined to women, a source, incidentally, of some medico-legal folklore. The undergraduate psychology courses of some thirty years ago used to cover the subject of hysteria by relating that it mimicked real disorders. This never-too-plausible and wholly inaccurate explanation is, astonishingly, still current. A well-known medical authority, writing for the general public—and repeating, by the way, the antique belief that hysteria "is limited almost entirely to women"—notes that "almost any disease can be imitated by hysteria . . ." and, discussing needless operations on hysterics, says, "hysterical manifestations mimic disease so closely that the real cause does not become evident until the incision is made." In other words, hysteria is not a disease, it is not "real," it only mimics something that is; one can only wish the good doctor would talk over the matter with psychiatrists who are baffled daily by it. As it is, he does not even suggest in this discussion that it calls for treatment.

One might as well here anticipate objections that telling patients with minor functional disorders that they are really ill will increase the incidence of iatrogenic illness. The psychiatrist, who must endeavor earnestly to convince the patient that he is really ill as a first step toward giving him insight and so making therapy possible, is not likely to take fears of increased iatrogenic illness too seriously. Which is more likely to produce such a disturbance: a patient's fear that he has a serious and mysterious illness which his doctor is too ignorant to recognize and treat, or a patient's knowledge that he has a minor emotional disorder which his doctor understands and is prepared to deal with?

The gain to mental hygiene alone from a better diagnostic procedure should be considerable. Patients whose doctors have diagnosed their stomach upset, insomnia or headache as caused by



simply-explained emotional factors will be readier with understanding that similar emotional factors can cause a frankly neurotic neighbor's queer behavior or a hospitalized psychotic relative's florid delusions. The understanding that minor emotional disorders are so widespread should do much to reduce still-prevalent fears and superstitions about the major derangements.

It is not all their fancy, that! Knowledge that the doctor is willing to recognize their illnesses as real, to diagnose them, and to treat them, should set many persons more firmly on the road to mental health.



## BOOK REVIEWS

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**Shock Treatments, Psychosurgery, and Other Somatic Treatments in Psychiatry.** By L. B. KALINOWSKY, M. D., and P. H. HOCH, M. D. 396 and xii pages. Cloth. Grune & Stratton. New York. 1952. Price \$8.75.

The discussion of the use of shock treatments, psychosurgery and somatic therapy in psychological disorders indicates the obscurity of their modes of action. Although the theories are not entirely satisfactory, empirically the methods in use do modify the disorders, sufficiently to maintain interest and research in the field. Therefore, there is need to review various concepts and experiences at certain stages in progress.

Kalinowsky and Hoch have presented an admirable compilation, summary and discussion of the literature and their own experience in their second enlarged and revised edition.

The bibliography of 52 pages indicates the extensive specific literature that was reviewed. The index of 16 pages is sufficiently detailed to allow rapid access to particular phases of material and discussion.

There is so much material to absorb that, although this is slow reading, it is greatly rewarding, especially if used as a reference book.

The text is well organized, clearly written, inclusive and up-to-date. It is recommended to all persons interested in mental disorders.

**How to Make Your Daydreams Come True.** By ELMER WHEELER. xii and 195 pages. Cloth. Prentice-Hall. New York. 1952. Price \$3.95.

*How to Make Your Dreams Come True*, by Elmer Wheeler, is a mixture of pseudo-psychology and strong common sense. While it is intelligent in approach, it is coupled with naïve viewpoints in argument and attitudes. Yet it is a highly interesting piece of writing because it is a strange compilation of the applied aspects of psychological insights. Mr. Wheeler is a direct writer, and he is also an easily read transcriber of ideas in anthology fashion. The contents of this book deal with education, the matter of money and success, the concept of decision, and the keys to success. The author then illustrates his views with some 25 case histories "of people who turned daydreams into success." The book suggests ideas, not necessarily novel ones, but entertaining anyway; it suggests ways and means of making marriage somewhat happier, at least economically speaking; it would have more individuals become leaders in community life by following simple formulas for such success. Perhaps there is a special virtue to such writings; but this reviewer fails to appreciate the "brilliance of the amazing formulas" advocated by Mr. Wheeler.



**Psychosurgical Problems.** Fred A. Mettler, M. D., Ph.D. (Professor of Anatomy, College of Physicians and Surgeons, Columbia University), editor for the Columbia Greystone Associates, Second Group of 36 Investigators. 357 pages with 56 figures; 4 plates; 57 tables. Cloth. Blakiston. Philadelphia. 1952. Price \$7.00.

Psychosurgical problems are brought more clearly into the open by this very thorough study of operated and control groups of schizophrenics. Operative measures included topectomy, venous ligation, thalamotomy, and thermocoagulation. No operative mortality occurred. A chapter on the follow-up of the original Columbia-Greystone patients two years after operation is included.

This method of study included social evaluation, general medical condition; neurological, olfactory and vestibular function and autokinesis; psychologic and psychometric studies; complex mental function; attitude, behavior time sampling; psychophysiological and psychiatric observations.

Thirty-six scientists "asked the questions of nature." As in so many research problems, what one expects and what one finds are two different things. To paraphrase Mettler: "Nature is always talking to us, and to the questions of this study she answered 'No.'" What were the questions?

A most important conclusion is noted on page 310: "... Since the continued expenditure of time and effort on conventional lines is not likely to be any more profitable in the future than in the past some effort should at least be made to look for different ways to establish categories to be studied. For example, it might be profitable to group psychiatric patients on their response to some physiologic or psychologic tests or configurations of these, or to employ statistical analysis of rating scales."

One is satisfied by the factual, unbiased observations and conclusions. Although these are objective and "manifest" in nature, no more reliable objective tests were developed in the four years of study to indicate how psychosurgery is effective. The research proceeded with the desire to eliminate the personal ideas and hypotheses of the investigators. Therefore, this text is of real value to all interested in the present techniques and problems of psychosurgery.

**Hear and Forgive.** By EMYR HUMPHREYS. 249 pages. Cloth. Putnam. New York. 1953. Price \$3.00.

This is a boring and practically unreadable book about an English teacher and writer. His conflicts are on the level of complete naïveté. The only amazing thing is that English critics "hailed" the book. It seems that Wilde's statement, "We have everything in common with America, of course, with exception of the language," needs some enlargement.



**Helping Older People Enjoy Life.** By JAMES H. WOODS. 139 pages. Cloth. Harper. New York. 1953. Price \$2.50.

In recognition of generally increasing concern for the aged, the author describes one method of meeting the needs of older people, the story of how Cleveland met the challenge by establishing "Golden Age Clubs," not "Old Age Clubs," to provide for older people an opportunity for further happiness and adjustment.

"This book," the author states, "is written primarily for the volunteer who wants to work with older people in what has come to be called Golden Age Clubs. It is not intended to be a manual on the principles and practices of group work in general. Many persons would like to be of service in this area, but frequently because their acquaintance with older people is limited they are afraid that the venture is beyond their capacities. This book is intended to reassure them and to help them get started."

The text is extremely well written and full of practical suggestions on how to conduct such community projects to bring further happiness and enjoyment to the aged. The book, therefore, should be of great interest to social workers, community agencies and anyone interested in the problem of making happier lives for our older generation.

**Mind.** A Social Phenomenon. By F. S. A. DORAN. 182 pages. Cloth. Sloane. New York. 1953. Price \$3.00.

F. S. A. Doran, author of *Mind: A Social Phenomenon*, is by training a surgeon and anatomist; by inclination he is an adroit philosopher and thinker. Dr. Doran deals most intelligently with the nature of the human mind, its content, its development, and, in conclusion, with patterns of culture as seen through the eyes of the scientist.

There are, according to the author, two distinct groups of opinion about the "nature" of the human mind: One viewpoint is that it is of a non-material, spiritual, even semi-divine and mystical character; and the other viewpoint is that the "mind" is composed of the same kind of "stuff" that goes to make up the physical universe, and that it probably is connected with the function of the brain and the central nervous system. The author also writes brilliantly on the position of the dualists as regards "mind." Thus he undertakes to cover illuminatingly and provocatively the ramifications of the subject.

*Mind* is a controversial book. It is sound in its arguments, in its examination of contrary opinions, in its conclusion that the human mind is an expression of brain function and that its content is determined by the social force of tradition and by the fears, hopes, prejudices, and values of those with whom we come in contact. And it is more than a controversial book; it is challenging and penetrating and scientific.



**Man's Search for Himself.** By ROLLO MAY, Ph.D. 281 pages. Cloth. Norton. New York. 1953. Price \$3.50.

Rollo May is not the simple psychologist who writes mere self-help books; his *Man's Search for Himself* is a strong, direct, sensible book that deals with intelligence and insight in the anxieties of modern man, the roots of the maladies of our time, man's experiences in living, the goals of integration of personality, the creative conscience, and the virtue of maturity generally. Dr. May rightly realizes, as a clinical and social psychologist, that many people not only do not know what they want in life, they often do not have any clear idea of what they feel in living. He handles well the major inner problems of people in our day. *Man's Search for Himself* prefaces its thesis with the sound statement that "One of the few blessings of living in an age of anxiety is that we are forced to become aware of ourselves." May speculatively develops a basic viewpoint, with his emphasis on finding values and goals that normal men and women can affirm in their day-to-day living.

The roots of our psychological malady, according to Dr. May, are these: the loss of the center of values in our society, the loss of the sense of self, the loss of our language for personal communication, and the loss of the sense of tragedy. What our society needs, then, in the author's opinion, is "not new ideas and inventions, important as these are, and not geniuses and supermen, but persons who can be, that is, persons who have a center of strength within themselves."

*Man's Search for Himself* is a speculative, philosophic, somewhat therapeutic book, only at times unscientific when the author over-indulges in stringing quotations together. But that is a minor flaw in an otherwise sound volume; and the book deserves high commendation for its lofty message, intelligent approach, scholarly value, and significant understanding of human beings.

✓ **The Annual Review of Psychology. Vol. 4. 1953.** C. P. Stone, editor. 485 pages. Cloth. Annual Reviews, Inc. Stanford, Calif. 1953. Price \$6.00.

This is the fourth volume in its series; it again presents a review of the psychological literature of a year. Most of the various fields of psychology are covered, although the individual articles often seem lacking in detail; and the volume is not complete in coverage of the entire area. The idea behind a text of this type is worthy. However, in view of the numerous fields of psychology, one wonders whether such an undertaking might not be more complete and more valuable if there were separate volumes for each of the major areas of psychology.



**Phantasy in Childhood.** By AUDREY DAVIDSON and JUDITH FAY. 188 pages. Cloth. Philosophical Library. New York. 1953. Price \$4.75.

This is an interesting and informative book on the development of fantasy in children. Written by two British women, one an analyst (Davidson) and the other a Froebel teacher and former writer (Fay) who has worked with individual psychotic children, the authors are of the Melanie Klein school and present their material from that viewpoint. The chapters progress roughly in the order of psychosexual stages, going from the oral stage through the latency period. The pattern of the book is the constant interweaving of theoretical material with concrete examples from individual cases. The last chapter "The Living-Through of Phantasies" presents, in detail, a single case. The book is well written and brings in many examples of fantasy from the field of children's literature. Although the authors state they have written in non-technical language, this is not a book for a lay audience, since it assumes familiarity with a considerable amount of theory. A practical aspect of the book is that much of the material has mental hygiene significance, and it should be valuable from that point of view as well as from the theoretical standpoint.

**The Art of Human Relations.** By HENRY CLAY LINDGREN. 287 pages. Cloth. Hermitage House. New York. 1953. Price \$3.50.

"The writing of this book," the author states, "was based on the premise that growth in the direction of emotional security may be added if we improve our understanding of ourselves and the people in our lives, particularly if we gain a better understanding of the relations between ourselves and others."

Most of the text material reflects the author's own experiences and insights gained from the theories and formulations of such workers as Harry Stack Sullivan, Patrick Mullahy, Clara Thompson, Karen Horney, and Erich Fromm. The text is simply written in understandable terms. It helps the reader to recognize and identify certain feelings and experiences, and to see ways in which they are interrelated.

**Derricks.** By JAMES BARR. 250 pages. Cloth. Greenberg. New York. 1951. Price \$2.50.

This is a collection of seven short stories about homosexuals, written in the by now familiar form of whining and naïveté. Not the slightest attempt is made at psychological explanation: "A man likes men that way or he doesn't, and that's all there is to it [p. 220]." Unfortunately, that's not all there is to it, and a good writer goes after the unconscious factors. As psychological novels, the present tales are just as unsatisfactory as the author's previous book, *Quatrefoil*, against which the identical objections were expressed in this *QUARTERLY*.



**Psycho-Analysis and Child Psychiatry.** By EDWARD GLOVER, M. D. 42 pages. Paper. Imago. London. 1953. Price 6/—.

In this brief, concise, and orderly monograph Dr. Glover has attempted a psychoanalytic explanation of childhood disorders, reaching back to infancy. Utilizing the psychosexual theory of development, and various attendant concepts of adaptive mechanisms, i. e., regression, projection, fixation, etc., he attempts to demonstrate how the organization of the ego and super-ego evolves from the amorphous collection of "instincts," sensations and impulses of early infancy. He sketchily considers how neurotic, pre-psychotic and psychotic patterns of behavior grow out of and are manifested at the various developmental levels, stating that two main groups of behavior may be distinguished: (1) "disturbances of functioning and development" and (2) "symptom-formation which in some respects resembles the psychopathological states observed in adults." However, it is questionable whether a diagnosis of psychosis can safely be made in the case of the three-year-old child the author cites. Not only is his evidence weak, derived from an analysis of the child, but it is also lacking in corroborative data from psychology. He discusses briefly the application of analytical treatment to childhood and infant disorders, including the basic free-association technique. But one feels that more fundamental in his treatment is the "rapport situation," typical of "non-directive" therapies, rather than analysis *per se*.

As with much analytical literature, some semantic confusion occurs, i. e., mention of "instinctual objects" and "instinctual experience." However, Dr. Glover is to be praised for his assertion "that psychoanalysts can no longer claim total exemption from the customary scientific controls . . . and must submit their observations to the most rigid statistical control." In all, this is a thoughtful and thought-provoking study which is to be recommended to those interested in an analytical approach to child psychiatry.

**The Sex Paradox.** By ISABEL DRUMMOND. 362 pages. Cloth. Putnam. New York. 1953. Price \$5.00.

Isabel Drummond compiles data on the different treatments of sex-offenders in different states, giving informative material on penalties imposed. The subtitle of the book, "An Analytical Survey of Sex and the Law in the United States Today," is a misnomer; the book is not an analytic one in the technical sense; the term is used in popular connotation. The author, a Philadelphia lawyer, is skeptical of the penal results, and conflicting theories; she advocates further study. It is regrettable for the scope of the book that her knowledge of the newer psychiatric-analytic literature on criminology is rather restricted and limited.



**Cerebral Mechanisms in Behavior.** Hixon Symposium. Lloyd A. Jeffress, editor. XIV and 311 pages with 45 figures and 3 tables. Cloth. Wiley. New York. Chapman and Hall, Ltd. London. 1951. Price \$6.50.

Six major papers and the discussions of 18 participants in the Hixon Symposium on "Cerebral Mechanism in Behavior" bring a very complicated subject into closer focus. Many thinkers and clinicians may find their own unexpressed problems and questions formulated in words, ideas, or theories, with some experimental evidence for and against them. The symposium has the typical effect on the reader, in that more facts and questions are propounded and under scrutiny than if he had merely listened to the major speakers. Sometimes too much is stated in a few sentences. Pet theories are pretty well clarified and "brought down to size."

The immense field involved in the discussions was viewed by recognized men in the fields of chemistry, electronics, mathematics, physiology, zoology, psychology, psychobiology, psychiatry, neurology, and philosophy.

Neuman, in his theory of automata (related to the field of cybernetics), conceives how machines can repair or "reproduce" themselves. de No and Weiss point out that machines are artificially made and by their limitations are precise and predictable while the human brain is more subject to error, is non-rational, and has memory. Lashley discusses the problem of "Serial Order in Behavior," covering the chain theory, mechanism of integration and speech. Kleevers shows the functional differences between occipital and temporal lobes. In his discussion, Nielson reports further studies in agnosia. Kohler discusses the "Relational Determination in Perception." Halstead brings intelligence under discussion; McCulloch integrates brain anatomy and physiology; Brosin looks at the symposium from the clinical side. A short name and subject index is presented.

This text is recommended for repeated reading.

**The Life and Times of Sir Edwin Chadwick.** By S. E. FINER. 555 pages. Cloth. British Book Centre. New York. 1952. Price \$7.50.

One of the outstanding crusaders in public health in Nineteenth Century England was Sir Edwin Chadwick. Despite the fact that the *immediate* concrete results of his work were negligible, the long-term effects are hard to overestimate. This biography is designed for the student rather than for the general reader—attention to his private life has been subordinated to a review of his public career—but at the same time the author has managed to make what could have been an exceedingly dull chronicle surprisingly interesting in spots.



**The Making of a Scientist.** By ANNE ROE, Ph.D. 244 pages. Cloth. Dodd, Mead. New York. 1953. Price \$3.75.

*The Making of a Scientist* is a well-known clinical psychologist's account of a pioneer research project designed to investigate the relationship between personality and vocational choice. The writer—working under the assumption that certain personality factors related to vocational choice would be present and possibly most evident in the men most successful at their vocations—selected 64 of the foremost American research scientists from the fields of the biological, physical and social sciences. Others were also studied so as to determine how closely the eminent men in each field resembled the majority of scientists in that field.

Although by no means definitive or conclusive, Anne Roe's book does leave one with some understanding of the kind of person the scientist is and why and how he became a scientist. However, this is not a technical report, but rather an endeavor to communicate some highly interesting findings to scientists and society in general. The psychologist reading this book will, therefore, find the data presented too insufficient to permit a critical evaluation of the generalizations and interpretations made by the author.

**The Mentally Retarded Child.** A Guide for Parents. By ABRAHAM LEVINSON, M. D. 190 pages. Cloth. John Day. New York. 1952. Price \$2.75.

A noted pediatrician writes with sympathy about the various aspects of mental retardation. He states from a medical point of view, not only facts that parents should know, but the important aspects of the education and management of the retarded child.

He offers parents hope and encouragement without misleading them into false optimism or ways of effecting "cure." Dr. Levinson feels that in almost every case something can be done to improve the child, and he outlines treatment.

Specialists in the field will be interested in a list of selected readings and—for counseling parents—a list of schools, both public and private, for retarded children.

**The Cup of Trembling.** By KARL BROWN. 312 pages. Cloth. Duell, Sloan & Pearce. New York. 1953. Price \$4.00.

*The Cup of Trembling* is a historical novel, centering around Harriet Beecher Stowe's unloved son, Fred. Nothing is known about the real Fred, except that the author of *Uncle Tom's Cabin* behaved peculiarly toward him. When he was seriously wounded at Gettysburg, she ignored even that fact. The author makes out of his hero a rebel against his mother's convictions, blaming her in part for the Civil War. Some historical details, and the family story of the famous woman are interesting.



**Psychosomatic Research.** By ROY R. GRINKER, M. D. 208 pages. Cloth. Norton. New York. 1953. Price \$3.50.

Recent years have seen a deluge of studies and hypotheses reaching print under the general term of "psychosomatic." For the most part, little attempt has been made to define "psychosomatic" carefully, and to systematize the broad and diverse formulations and methodologies which have appeared. The object of this book is to present a critical approach and evaluation of contemporary work and to attempt to formulate a comprehensive theoretical framework as a basis for future research.

It is Grinker's belief that past psychosomatic research has gone astray through too intense an interest in the correlation of specific emotional states with specific somatic systems, and "has led to the premature spreading of tentative hypotheses."

"Psychosomatic" means more than a kind of illness. It is a comprehensive approach to the totality of a process that takes in many systems: somatic, psychic, social and cultural. Grinker states that research must take two approaches; (1) "a study of maturation and differentiation of psychosomatic processes" and (2) "the use of multidisciplinary (the medical, biological and social sciences), simultaneous and prolonged observations of many phases of. . . psychosomatic processes." He considers his theoretical framework to be holistic in nature—a field theory. The field ranges from the "enzymatic system" to the "socio-cultural system." Not just the nature of somatic functions, or psychological processes, should be studied. Rather, "all the forces contributing to psychosomatic unity, development, differentiation and unhealthy disintegration" are the proper area of investigation.

Dr. Grinker presents a brief and concise history of psychosomatic concepts and an exposition and evaluation of the hypotheses of the major workers in the field today—with a specific review of the "structure and function of the mouth" followed by a discussion of the "psychological implications of oral functions." An extensive bibliography of source material is provided.

This is an excellent summary of contemporary work in psychosomatic medicine and an important outline of a theoretical framework which could well be the basis for much constructive research in the future.

**Stephania.** By ILONA KARMEL. 375 pages. Cloth. Houghton-Mifflin. Boston. 1953. Price \$3.75.

*Stephania* is a bitter and meaningless book about three women in a Swedish hospital. The author, a protégé of Archibald MacLeish, has a tragic life of Nazi persecution and concentration camp behind her. She is entitled to sympathy; but as a writer, she confuses bitterness with literary aims.



**Understanding Stuttering.** By A. B. GOTTLÖBER, Ph.D. 274 pages. Cloth. Grune & Stratton. New York. 1953. Price \$5.50.

With over 1,300,000 stutterers and stammerers in the United States, this book is important emphasis upon the need to understand and remedy a speech handicap which affects the individual's adjustment throughout life. The author defines stuttering and stammering as "blocking," i. e., a functional disorder. It has its roots in a reaction against "anxiety producing situations and develops through conditioning." The individual "will not recover unless he can learn to cope successfully with anxiety producing situations." The "blocking" process may be "reversed" through the early application of treatment which involves: education into the nature of speech difficulties, reconditioning of speech patterns, relaxation and psychotherapy. A detailed discussion of each phase is provided by the author.

The author correctly emphasizes that "blocking" is a function of the whole organism, not of the speech apparatus alone, and that "not the pattern of speech, but his pattern of living is our prime concern and should be his." This "first-aid manual for stutterers," written in a simplified, consulting-room style, is addressed primarily to a lay audience, but is urged upon physicians and social service professions as a valuable guide.

A brief and elementary discussion of the neurophysiological basis of speech production—with illustrations—is provided.

**The Power Within.** By Sir ALEXANDER CANNON. 208 pages. Cloth. New York. 1953. Price \$3.00.

The author has traveled to many corners of the earth seeking reliable instances of occult phenomena. He reports that he has demonstrated many of his findings in his own laboratories.

"The purpose of this book," it is stated, "is to make the reader master of himself, and a source of good in the world, to bring happiness and peace to mankind, above all, to acquire a sound knowledge of the conscious, sub-conscious and unconscious states of mind and how they work; for to know mind is to know God."

The discussion seems to be based on mystic Oriental concepts. It includes in this framework discussions of sleep and dream states, levels of consciousness, instinct, emotions, and mental processes. There is a chapter dealing with abnormal states of mind which covers almost all clinical entities. The author's viewpoint aside, he adds supporting evidence to the view that clairvoyance, telepathy and similar phenomena call for serious scientific consideration.



**Proceedings of the Second Research Conference on Psychosurgery.**

Public Health Service Publication No. 156. Winfred Overholser, M. D., editor. 116 pages. Paper. Federal Security Agency. National Institutes of Health. U. S. Government Printing Office. Washington, D. C. 1952. Price 75 cents.

The research conferences on psychosurgery draw in a wide variety of fields, from the nation's specialists who deal with the psychosurgical patient or the potential patient for psychosurgery.

The second conference, presided over like the first by Fred A. Mettler, M. D., covered in particular the classification of patients and the practical and theoretical considerations involved in hospitalization and treatment. The questions of affectivity, deterioration and creativity were presented and discussed exhaustively. Robert A. Cleghorn, M. D., led the discussion of "Base Line Data and Psychiatric Categories"; Hester B. Crutcher discussed "Evaluating the Environmental Situation of the Mentally Ill Patient" and Robert G. Heath, M. D., presented an "Analysis of Schizophrenia." The much-discussed matter of creativity in psychosurgery patients was presented by Joseph Zubin, Ph.D. An appendix to the report gives the "Descriptive Scales for Rating Currently Discernible Psychopathology" by J. R. Whittenborn, Ph.D.

Like the first research conference report, this small volume is essential background material for all administrators and clinicians dealing with psychosurgery.

**Afraid in the Dark.** By MARK DERBY. 280 pages. Cloth. Viking. New York. 1952. Price \$3.00.

Here is a British thriller, making full use of the improbable: a search for a Malayan sadist who tortured women in a Japanese concentration camp, a search conducted without benefit of the authorities, and executed by a neurotic ex-captain, paid by the husband of one of the victims. The technique of the narrative is routine; the author passes up an opportunity to explain the psychology of sadism. Of course, Mr. Derby does not consider carrying out such an unorthodox idea.

**The Intimate Life.** Or the Christian's Sex-Life. By NORVAL GELDENHUYS, B. A., B. D., Th. M. 96 pages. Cloth. Philosophical Library. New York. 1952. Price \$2.75.

The author states that this is an abridged portion of his book, *Marriage*. It discusses intimate facts and principles of pre-marital and of marital life. It frankly and explicitly describes the moral and spiritual issues involved. It is the type of book which priests and ministers could safely recommend.



**Medicine.** Volumes I and II. Hugh G. Garland, M. D., and William Phillips, M. D., editors. 2,146 pages including index. Cloth. St. Martin's Press. New York. 1953. Price \$25.00.

This is an extraordinarily comprehensive British system of medicine. It is a compendium of the work of 42 distinguished authorities, 40 of them now practising or teaching in Great Britain or Ireland and the other two elsewhere in the British Commonwealth of Nations. It is splendidly illustrated, beautifully printed and well bound. It is, in fact, an excellent example of the best type of British scientific text. The American physician will find it of unusual interest as covering adequately, and with no apparent bias, problems of social medicine and public health. There are 167 pages of "art plates," seven in color, besides numerous halftone and line illustrations throughout the text.

The two volumes cover the whole medical field, dividing it into 40 sections. These include treatment of such matters as genetic factors in disease; nutrition; industrial diseases; aviation medicine; and such tropical diseases as are important in temperate zones. Psychiatric and neurologic disorders are treated entirely separately and are not even in the same volume. The discussion of psychosomatic medicine, the psychoneuroses and psychoses would meet with general American approval.

Unfortunately for the purposes of a great over-all picture, however, discussion by individual specialists is bound to be authoritative on matters about which there is no general unanimity of opinion. For example, David N. Parfitt, M. D., who is consultant psychiatrist and medical superintendent of Holloway Sanatorium, Virginia Water, Surrey, is the author of the chapters on the psychoneuroses and the psychoses. He is ambivalent, to say the least, about masturbation: "Where the habit is associated with much mental disturbance it is merely a symptom of a more serious nervous illness. . . ." And: ". . . In the long-term interests of character formation it is better controlled." As for psychoanalysis, which is discussed under treatment of the psychoneuroses, Parfitt says: "Psychoanalysis should be avoided until other methods have been given adequate trial. Not only is the treatment excessively prolonged—it may stretch into years—but about half of the patients analysed fail to improve and some few are made worse." Parfitt does, however, find conditions in which analysis is indicated.

The reviewer has no wish to carp about this sort of thing. *Medicine* is not a general physician's guide to practice but a text for medical teaching. Any specialist can disagree with conclusions reached in almost any such text but the latter can be a splendid basis for instruction nevertheless. American medical readers should find these volumes, not only an excellent teaching instrument, but a splendid and often-consulted addition to any institution or personal medical library.



**Psychiatric Dictionary.** Second edition with Supplement. By LELAND E. HINSIE, M. D., and JACOB SHATZKY, Ph.D. 781 pages. Cloth. Oxford University Press. New York. 1953. Price \$15.00.

Drs. Hinsie and Shatzky have brought out an enlarged second edition of their invaluable psychiatric dictionary, first published in 1940. Compiled by the assistant director and the research librarian of the New York State Psychiatric Institute, with the aid of a strong group of specialist-collaborators, their first edition has been, not only a standard, but an indispensable, reference work. The definitions of this dictionary are encyclopedic, with much quotation from standard authors.

While such a dictionary as Dr. Richard H. Huthings' *Psychiatric Word Book* is more compact and is thus handier and easier to use as a student's pocket volume or a practitioner's desk reference, Hinsie and Shatzky's book gives original meanings, shades of meanings and terms no longer current, which cannot be included in a handbook but are of great importance for the scholar.

The form of the new edition is enlarged by a supplement covering some 900 terms and concepts which are either new or were overlooked when the original dictionary was compiled. This supplement covers 218 pages of the new volume. It has the drawback, of course, of compelling the user of the dictionary to check two separate vocabularies for definitions. This form also means that the original body of definitions has been picked up for re-publication without change. Some modifications that the captious might find desirable could not, therefore, be made. There are several instances, for example, of the use of the term "insanity"—not under the main definition but in other references—without noting the present generally observed restriction to a legal sense. The method of binding a supplement into the new edition, however, has an important advantage. The original plates can be used for the greater part of the book, and the cost thus kept within reasonable limits.

**Anatomy of the Nervous System.** Ninth edition. By STEPHEN WALTER RANSON, M. D. Revised by Sam Lillard Clark, M. D. 581 pages. Cloth. Saunders. Philadelphia. 1953. Price \$8.50.

The ninth edition of this standard text and reference volume has been materially enlarged and revised since the eighth edition was published in 1947. "Significant advances in neuroanatomy and neurophysiology," says Dr. Clark in the preface, "have been made in many directions and by recent investigators from various disciplines. . . . It is hoped that the incorporation of new material and illustrations and the re-writing of many portions of the text in this revision will make it more usable." Besides revision and enlargement of the text, both bibliography and index items have been increased, adding materially to the value of the volume.



**Contributions Toward Medical Psychology.** Volumes I and II. Arthur Weider, editor. 885 pages including index. Cloth. Ronald Press. New York. 1953. Price \$12.00.

The title of this book should be read in the current American rather than the old-fashioned sense. Weider's "medical psychology" is not psychiatry, but is the collection of psychological procedures employed by the clinical psychologist and/or the psychiatrist for the estimation of mental states. His review covers material presented by specialists in widely varying fields of human development. For instance, the authors on the Rorschach techniques are Beck, Munroe, Harrower and Kellman. Gesell covers human infancy and the embryology of behavior. Kluckhohn and Mowrer are the discussants respectively of "Determinants and Components of Personality" and "What is Normal Behavior?" Franz Alexander writes on the psychological aspects of medicine.

Volume I of this compilation covers the general subjects of "Psychology and Medicine," "Some Aspects of Psychology" and "Psychosomatic Relationships." Volume II, Part IV of the collected work, is devoted to psychodiagnostic methods and medical practice.

The whole work is a comprehensive and important reference volume for teaching and general use. Its value to the psychologist is self-evident. In addition, this reviewer thinks it belongs in every medical library where psychiatric and psychological references are likely to be needed. It should be invaluable to the medical practitioner or administrator who needs "refresher" information on psychological subjects, or who needs to know just what the psychologist can be expected to do for him in the course of medical administration or medical practice.

**The Loves of Florizel.** By PHILIP LINDSAY. 208 pages. Cloth. Roy Publishers. New York. 1952. Price \$3.50.

George IV was brought up in the rigorously puritanical family of that unfortunate psychotic, George III. He was personally unattractive as a child; he was educated by harsh tutors; he appears to have had little love from his parents. His subsequent career as a royal debauchée could be explained simply as a reaction to this unroyal bringing up. He was a boor, a drunk and a he-trollop. Philip Lindsay has written a readable, light, and, on the whole, entertaining story of the king's excursions from drink to women and back to drink again. Lindsay writes for the general reader. His story of England's certainly most idle, and possibly most disliked king, is not a psychiatric study, but it includes the material from which one may well judge a character organization and its origins.



**The Devil Rides Outside.** By JOHN H. GRIFFIN. 596 pages. Cloth. Smith's Inc. Fort Worth. 1952. Price \$4.00.

Here is a strange book about a young American musicologist whose studies lead him to spend some months in a French monastery. The hero is completely out of focus; neither his strange adventures, nor his obsession with chastity, nor his attraction for mystical problems are explained. On the other hand, besides adolescent writing, are some glimpses of future possibilities. Some of the monks, and a middle-aged woman, Mme. Renée, are interestingly described. The book is nearly 600 pages long; most of it is difficult to take; one expects the story of a conversion, but nothing happens.

**Women.** A. M. Krich, editor. 311 pages. Paper. Dell. New York. 1953. Price 35 cents.

This is an incongruous compilation of excerpts from such authors as Havelock Ellis, Helene Deutsch, and Therese Benedek, mingled with dubious statements on frigidity by the anthropologist, Margaret Mead, and ending with a worthless paper of O. Schwarz on love. It is problematical whether such compilations make sense.

**Marriage, Morals and Sex in America.** By SIDNEY DITZION. 440 pages including index. Cloth. Bookman Associates. New York. 1953. Price \$4.50.

Sidney Ditzion has compiled a not-too-pedestrian review of marriage and sex morality in America from colonial times to Kinsey. It is a tremendous collection of the significant and the trivial.

The reviewer thinks it an excellent work for any student of social science but believes it covers too much territory for accuracy in detail. It is, however, the handiest reference he has seen on this particular subject and is to be recommended—with the reservation that it should not be accepted as a primary source—for general reading and library use.

**Language and Myth.** By ERNST CASSIRER. 103 pages including index. Dover Publications. New York. 1946. Price (paper), \$1.25; (cloth) \$2.25.

The scientist who is concerned with the private language and the private mythology of the deranged individual must view his findings against the backdrop of word and myth of early mankind. Professor Cassirer was an internationally renowned authority on the phenomena of myths and their history, and on the phenomena of language development. This very short volume is an introduction to his findings and philosophy. This volume is well designed and is clearly printed on good paper. A paper-bound edition for students sells at \$1.25, about half the price of the regular edition.



**Elementary Statistics with Applications in Medicine.** By FREDERICK E. CROXTON, Ph.D. 376 pages including index. Cloth. Prentice-Hall. New York. 1953. Price \$7.50.

It would be difficult to exaggerate the need for such a book as this in the strictly medical field. The poor handling of statistics presents a problem familiar to anybody who handles medical manuscripts. Professor Croxton says: "Although this book deals with elementary statistical methods, it is hoped that it will be widely useful to workers in the medical and allied fields. No previous study of statistics is assumed, and only a very modest knowledge of mathematics is required."

The reviewer thinks this is an understatement. It is true that the author has exercised the greatest care to explain his statistical procedure point by point and symbol by symbol. It is also true that he has gone to the greatest pains to give mathematical backgrounds, derivations and rationales of common, standard statistical procedures. He does not, however, chart any royal road to statistics. The understanding and application of his methods will be difficult for anybody who has not had a considerable grounding in mathematics. They should not, however, be impossible.

The book covers: rates, ratios and percentages; tabular and graphic presentations; frequency distribution; measures of central tendency; dispersions, skewness and kurtosis; linear correlation of two variables; non-linear and multiple correlation; the normal curve; the reliability and significance of arithmetical means and of proportions; the Chi square test; significance tests for variances and tests for correlation coefficients. There are 14 appendices of various data for use in scientific statistical work, ranging from ordinates of the normal curve to tables of squares, square roots and reciprocals and a table of logarithms.

In this reviewer's opinion, this book should be in the hands of everybody who is reporting, or is likely to report, scientific material. He feels there is particular need for such a reference and guide in the fields of psychiatry and psychology where statistical methods are all too often far from professional.

**Cradle of the Sun.** By JOHN CLAGETT. 304 pages. Cloth. Crown. New York. 1952. Price \$3.00.

Clagett writes of a tragic period in history, the downfall of the Maya peoples before the Spanish conqueror. There is in the fact of the conquest and in the psychology of the conquerors and the conquered a setting for a tale of major tragedy with its psychological foundations. Clagett has attempted no such thing. He has not written a tragedy; he has not even written a psychological story; but he has written a grand adventure tale, seemingly faithful to its social and historical background—and this was doubtless all he intended.



**King Turd.** By ALFRED JARRY. Translated by Beverley Keith and G. Legman. 189 pages. Cloth. Boar's Head Books. New York. 1953. Price \$4.00.

Whether one credits the story that Alfred Jarry composed his anal masterpiece *King Turd* as a schoolboy satire does not really matter. It could have been written by a boy of 14 whose ideas of revolt were circumscribed by the "dirty words" scrawled on public toilet walls.

*King Turd*, a play whose production scandalized Paris in 1896 when its author was 23, is the drama of a human race fit only to be thrown down the privy. If it is childish, so were Gulliver's Yahoos who climbed trees to throw feces at passersby. The author was as mentally disordered a person as any who ever achieved literary notoriety. His masterpiece could serve as a psychiatric text on the anal erotic stage of emotional development. *King Turd* is exactly what his title implies. All the other characters inhabit the latrine. Their language is latrine language. There is nevertheless a certain light-hearted abandon in Jarry's scatological sadism. Humans are feces, says he, but who cares?

The reviewer fears this translation is likely to be dismissed as a piece of purposeless scatology. He thinks, on the contrary, that it is a most interesting human document, well worth reading by anybody concerned with the dynamics of the mind. And, oddly, if one can be emotionally mature about the scatology and the cruelty involved, it is not without a certain, perhaps childish, entertainment value besides.

**An Introduction to Projective Techniques.** Harold H. and Gladys L. Anderson, editors. 720 pages including index. Cloth. Prentice-Hall. New York. 1951. Price \$6.75.

The Andersons have compiled a basic volume—which is winning increasingly high regard—on the projective techniques which are the basis of much modern psychiatric diagnosis and clinical psychology. The contributing authors are widely known and are, for the most part, recognized authorities. The book covers, often in enough detail for emergency use as a manual for administration, such techniques as the Rorschach, the TAT, word association and sentence completion tests, the Bender Visual Motor Gestalt, human figure drawing, fingerpainting, graphology and the Szondi test. A section of general intelligence tests, as used for personality appraisal, takes up the Wechsler-Bellevue and the Stanford-Binet. Another section covers therapeutic uses of puppetry, play and psychodrama. This book is a useful desk reference for any psychologist or student of psychology and it should be of even wider use for the psychiatrist who wishes to look up the application or the possibilities of specific psychological techniques.



**The Natural Superiority of Women.** By ASHLEY MONTAGU. 194 pages. Cloth. Macmillan. New York. 1952. Price \$3.50.

Ashley Montagu is one of the most socially useful of our social scientists. His work for UNESCO and elsewhere in combating race prejudice, for example, has been widely recognized by psychiatrists as well as anthropologists.

In the present book Professor Montagu has let his overflowing good will overflow too far. Men and women are different, as most children are aware, and as the continuing growth of population testifies. Professor Montagu itemizes the differences, known and not so well known, physical and emotional and/or mental. He concludes that women are the superior sex and that the hope of mankind is in women. "Maternal love is the purest and at the same time the most efficient form of love because it is the most compassionate, because it is the most sympathetic, because it is the most understanding and the least censorious." Distortion of this emotion is also productive, this reviewer would note, of "Momism."

Some of Professor Montagu's data are doubtful; a great many of his interpretations are more than doubtful; and many of his conclusions are *non sequiturs*. It is probably general psychiatric opinion, founded on sound research and long clinical experience, that men and women are necessarily complements of each other. There is no sound medical or psychological evidence of which this reviewer is aware to lead to the conclusion that, because they are different, one is superior to the other.

This reviewer begs to doubt also whether there is a sound social reason. Women have long suffered from the self-arrogation of the male to a position of false superiority. We see no good reason now to reverse the process. Speaking as a scientist, Bertrand Russell recently wrote in *The Impact of Science on Society*: "If you say that the rich are abler than the poor, or men than women, or white men than black men, . . . you proclaim a doctrine . . . which is almost certain to lead to either slavery or war." One could just as well read here Professor Montagu's suggestion that women are abler than men. This reviewer thinks the balance of science and of sound political thinking is on the side of Russell.

**Fool's Haven.** By C. C. CAWLEY. 210 pages. Cloth. House of Edinboro. New York. 1953. Price \$2.75.

The author of this novel evidently aimed at a crusading volume against the variety of faith-healing which inflicts death on the innocent rather than call on medicine. The idea is excellent, the characters lifeless, the plot implausible; and the whole conclusion misses its objective by several light years. This is a pity, because it is all to the good of mental hygiene to promote wider interest in this subject.



**The Palm-Wine Drinkard.** By AMOS TUTUOLA. 130 pages. Cloth. Grove Press. New York. 1953. Price \$2.75.

This is a fascinating tale by a native West African writer whose English is his personal achievement and whose hero would, by any western standards, be considered an at least amoral psychopath.

The palm-wine drinkard, like Dante, visits the land of the dead. He performs magic; he meets a Skull who seems to be a "beautiful 'complete' gentleman" with a fatal fascination for ladies; he lives in a white tree and flies through the air with the aid of his juju. But this is no artlessly primitive tale. The drinkard carries a gun, trades with British money, sits in judgment in a court with a travesty of English rules and compares his juju-flight through the air with a plane trip. He also meets a crowd of dead babies, is sheltered inside the tree trunk by a "faithful-mother," finds an egg which feeds the world, is swallowed and regurgitated by a fearful "hungry-creature" and finally sends a slave "to heaven" in what seems to be human sacrifice.

This book is a serious one; the West African society it concerns would certainly recognize it as fantasy, but as appropriate fantasy; it is simply based on concepts and told in language which are not of our world. If a gifted western writer could present a hallucinatory tale in pure art, we might have something like this.

**Mr. Cantonwine.** By LIONEL BARRYMORE. 218 pages. Cloth. Little, Brown. Boston. 1953. Price \$3.00.

The purpose of Lionel Barrymore's "moral tale" is a bit difficult to come by, unless it is to illustrate in the language and ideas of a century long gone the fact that a harlot's life is not a happy one. Barrymore's story involves an unsophisticated but selfish young lady who runs off with the villain; an itinerant preacher; a captive bear; a talking crow; and an anachronism or historical distortion or two which a well-disposed reviewer can only suppose to be deliberate. There is, however, something entertaining in this artless hodge-podge and maybe even something profitable enough to repay the reading.

**The Face and Mind of Ireland.** By ARLAND USSHER. 191 pages including appendix. Cloth. Devin-Adair. New York. 1950. Price \$2.75.

Ussher's book has had wide critical acclaim, more in literary and philosophical than in sociological or psychological circles. It is, however, a brilliant picture of the surface social psychology of one of our most ancient cultures and newest nations. Any person who would understand Ireland or Ireland's children in the United States—including those children themselves—cannot but be the richer for its reading.



**Hope for the Troubled.** By LUCY FREEMAN. 256 pages including index. Cloth. Crown. New York. 1953. Price \$3.00.

Lucy Freeman, who writes much on psychiatry and mental hygiene for the *New York Times*, and who is the author of an account of her own psychoanalysis, *Fight Against Fears*, presents in *Hope for the Troubled* the best general discussion this reviewer has yet seen of where the mentally distraught may go for aid and of what kind of help they may expect to find there. She discusses briefly the genesis of mental disorder, the development of scientific resources for its amelioration and the help that can be afforded by counselor, psychologist and psychiatrist.

"The deepest form of help available to the troubled," she notes, "is psychoanalysis." Miss Freeman devotes a couple of excellent chapters to an adequate discussion of the unpleasant fact that psychiatric difficulties are too often mistaken for physical. She discusses hospitals and treatment methods. As a person greatly benefited herself by psychoanalysis, she is, understandably, less than enthusiastic about psychosurgery and shock, but she is no fanatic. A chapter of this book is very usefully devoted to the quack therapies from astrology to "Yoga." She is firm in her belief that the troubled can find help; and her book is an excellent guide for those who need it.

Besides the text, there is an appendix listing state mental health associations, federal agencies, national professional organizations and counseling agencies.

**The Life-Giving Myth.** By A. M. HOCART. 252 pages including index. Cloth. Grove Press. New York. 1953. Price \$4.00.

*The Life-Giving Myth* is a short collection of essays, notes and brief discussions by a distinguished anthropologist whose papers were collected and edited after his death. In the introduction, Lord Raglan notes: "Myth, ritual and social organization are inseparably connected and cannot profitably be studied apart." To these, this reviewer thinks, should be added personality organization.

Hocart's volume is of basic worth to people interested in the fundamental correspondences between the mythology of the race and the personal mythology of mental aberration.

**Tomorrow the Harvest.** By VIOLA PARADISE. 316 pages. Cloth. Morrow. New York. Price \$3.50.

An unfortunate book transforms an interesting setting into boredom personified. Setting: Maine in Revolutionary days. End effect: The book is barely readable.



**More Clinical Sonnets.** By MERRILL MOORE. 72 pages. Cloth. Twayne Publishers. New York. 1953. Price \$3.00.

Merrill Moore is an eminent psychoanalyst who finds outlet for some of the impulses that too many of us repress in what his publishers call Freudulent verses. Dr. Moore's idea of what constitutes a sonnet is somewhat elastic; he will never receive a literary prize from the traditionalists, but his work is smooth, is sophisticated and is excellent versification. His source, of course, is in the great mine of his patients' unconscious and his own. Subjects of his latest little volume range from a "dodunk" whose enemies had a term for him that would bar a less responsible author from the mails, to the need for psychiatrists. Says he:

"There is no shortage of psychiatrists—

There are enough in spite of what some tell

To cure the patients who really want to get well."

The psychiatrist who, as all good psychiatrists should, has retained his sense of humor, will find this volume delightful, as will the more sophisticated of his friends and patients.

**Trial of Peter Griffiths.** George Godwin, editor. 219 pages. Cloth. British Book Centre. New York. 1950. Price \$3.50.

Peter Griffiths was a sexual psychopath who raped and murdered a child, was tried for it, convicted and sentenced to death. His trial is of considerable interest to psychiatry because of its modern (1948) application of the M'Naghten rules in a British court, and because of the conflicting testimony of the medical experts, and the study appended to the trial record, "Schizophrenia and Other Mental Disorders of Medical-legal Import" by C. Standford Read, M. D., consulting psychiatrist to the West End Hospital for Nervous Diseases. The charge to the jury, in which Mr. Justice Oliver summarizes the medical evidence and discusses whether this or that matter of the defendant's conduct is consistent with schizophrenia, is particularly worthy of attention.

*Trial of Peter Griffiths* is Volume 73 of the expertly edited and well presented *Notable British Trial Series*. It is of considerably more psychiatric interest than are most of those volumes.

**Cast the First Stone.** By CHESTER HIMES. 346 pages. Cloth. Coward-McCann. New York. 1952. Price \$3.75.

In a novel on prison life, the factuality of the incidents cannot be checked by an outsider; but the psychological elaboration—unconscious masochistic provocations and homosexuality—can. Both are wrongly described; not the slightest inkling of the true unconscious meaning of eriminosi can be detected. Paradigmatic is the fact that clear-cut unconscious provocations for the purpose of libidized punishment are described as "temper."



**Science and Human Behavior.** By B. F. SKINNER. 461 pages. Cloth. Macmillan. New York. 1953. Price \$4.00.

B. F. Skinner is an eminent psychologist of the behaviorist school who is best known for his development of a system of behavior that is based upon his observation of animal behavior in a type of experiment which he developed. The theories and experiments related to this system were summarized and presented, without more than the most casual references to human behavior, in his *The Behavior of Organisms* (1938). His present work, *Science and Human Behavior*, is an attempt to extend his system into the field of humanity.

In this book, Dr. Skinner contends that "behavior is a lawful scientific datum" which can be predicted and controlled with the same kinds of lawfulness that apply generally to the natural sciences. Working on this assumption, he attempts to present a direct, scientific analysis of the conditions and influences determining behavior in an effort to reveal the rules that govern it and to acquire a comprehensive picture of the human organism as a behaving system. Once having evolved common formulations of the behavior of the individual, the author discusses the issues relative to man's social behavior and social environment, as well as the special problem of the control of human behavior as it applies to the fields of government, religion, psychotherapy, economics and education.

Skinner's book represents a commendable attempt to apply the scientific method in the development of an original and comprehensive system of behavior theory. It is highly recommended to those interested in the scientific approach to this problem.

**Two Essays on Analytical Psychology.** By C. G. JUNG. Volume 7 of the Collected Works. x and 329 pages. Cloth. Pantheon. New York. 1953. Price \$3.75.

These essays, on "The Psychology of the Unconscious" and "The Relations Between the Ego and the Unconscious" are important subsidiary works that help formulate the Jungian theories. Students of the development of the various psychological schools will find this book of great value, because the editors have included, not only the essays as finally revised by Jung, but also the original papers from which they are derived. The later revisions of these essays have been of two types: needed amplifications and expansions of the original and also the working in of Jung's own present theories concerning the collective unconscious.

The criticisms expressed in this book of both Freud and Adler, and the comparisons between them, are interesting and comprehensibly written. This reviewer found much more difficulty in following the author when he propounded his own theories.



**Hypnotherapy in Clinical Psychiatry.** By HAROLD ROSEN, Ph.D., M. D.  
XII and 313 pages including references and index. Cloth. Julian Press. New York. 1953. Price \$5.00.

Dr. Rosen's book is a detailed and comprehensive account of his own clinical research and experience with patients seen for consultation, evaluation and/or treatment under hypnosis. In it, he attempts to present an idea of the goals, scope and potentials, as well as the limitations and dangers, of this technique as it is employed in medical practice. Considerable attention is devoted to the problems of psychosomatic medicine with emphasis on the utilization of hypnosis in the differential diagnosis of emotional from organic pathology, and on the treatment of psychogenic factors which create organic difficulties or hinder recovery from medical or surgical conditions. The writer also discusses, describes and illustrates, with detailed case protocols, some of the more specialized hypnotherapeutic techniques, such as trance induction and termination, radical hypnotherapy, hypnotic unmasking, intensification and recognition of an emotion, and abreactive techniques.

The writer emphasizes that hypnotherapy, as any other form of meaningful therapy, must not be applied rigidly and automatically without an understanding and consideration of personality dynamics, interpersonal relationships and the growth or therapeutic process. Rather, as Rosen states: "We are patient, not hypnosis oriented. Hypnosis, to us, is neither a therapeutic agent nor a therapeutic technique. Patients with operable organic disease when treated surgically, are operated upon not by but under anesthetics; and patients with severe emotional disease, if hypnotized, are, likewise, to be treated psychotherapeutically not by but under hypnosis."

This book should be of primary interest and value to those interested in the theoretical or practical aspects of hypnotherapy in the various phases of clinical or medical practice. However, at least a basic knowledge of psychotherapy and hypnotic techniques is required for full understanding and appreciation of Rosen's work.

**True Tales from the Annals of Crime and Rascality.** By ST. CLAIR  
McKELWAY. 339 pages. Cloth. Random House. New York. 1950.  
Price \$3.00.

This is a series of sketches and personality notes, written in the brisk style of the *New Yorker* and reprinted from it. Their subjects range from Father Divine and Fire Marshal Brody, New York's chief catcher of pyromaniacs, to Harry Bridges' adventures in dodging the FBI. There is a good deal of interesting information and good sound characterization behind the bright façade of Mr. McKelway's style—and a lot of good entertainment besides.



**Your Brain and You.** By G. N. RIDLEY. xiv and 209 pages. Cloth. Watts & Co. London. 1952. Price \$4.00.

In *Your Brain and You*, the author has endeavored to explain the structure, function, growth, and evolution of the human brain in a manner to be understood by the general reader. As Ridley states, "This is not a textbook. It is addressed primarily to the ordinary reader who wants to get a working knowledge of his nervous machinery without the necessity of having to cope with the technicalities which are, properly speaking, the concern of the professional neurologist."

Ridley gives a lucid and readable account of the human brain; its development and mode of functioning without, for the most part, attempting to include psychological work. Indeed, it is when the writer departs from the purely physiological aspects of the brain, and attempts to touch on psychosomatic relationships that he does appear to go astray.<sup>6</sup> It seems, for example, that Ridley demonstrates a certain degree of naïveté about the fields of psychiatry and psychology when he states that, "The majority of people . . . endure hardships and dangers in war without any visible damage to their sanity. The few who crack under the strain almost always do so because they have inherently unstable minds."

**Marital Infidelity.** By FRANK S. CAPRIO, M. D. 272 pages. Cloth. Citadel Press. New York. 1953. Price \$3.50.

Caprio frequently writes from a psychoanalytic point of view. This volume, however, is largely on the ego level. It deals "practically," with numerous examples, with the problems brought about by marital infidelity without going into dynamics. It is a "sensible" book. As such, it is excellently adapted for counseling purposes. A clergyman called upon for advice might find it of considerable value. So might a general counselor on human relations or even a psychologist or psychiatrist who is called upon for counsel and advice rather than treatment.

**The Revolution in Physics.** A Survey of Quanta for the Layman. By LOUIS DE BROGLIE. 310 pages including index. Cloth. Noonday Press. New York. 1953. Price \$4.50.

One of the world's great physicists undertakes to write a non-mathematical discussion of atomic structure and quantum theory. It is a sound exposition of the facts for orientation or re-orientation in the basic data of science. The psychiatrist, so often accused of dealing with the intangible and the incomprehensible, will be interested in the same problem in the fundamental theories of matter and energy. Implications of the sub-title to the contrary, the "non-mathematical" nature of this survey does not make it easy reading. A good grounding in general science is a prerequisite.



**Psychoanalysis and the Occult.** George Devereux, Ph.D., editor. 432 pages including index. Cloth. International Universities Press. New York. 1953. Price \$7.50.

George Devereux, who seems not thoroughly convinced himself, has collected and presents impartially an important series of papers on extrasensory phenomena in the psychoanalytic setting. The contributions range from half a dozen by Freud himself, through a long list of subsequently published articles, to two new contributions, by W. H. Gillespie, and Sidney Rubin, respectively, written particularly for this compilation. Of the six parts into which the material is broken down, one is devoted to what Devereux calls "the Eisenbud—Pederson-Krag—Fodor—Ellis controversy" which covers articles chiefly published in *THE PSYCHIATRIC QUARTERLY*.

A collection of material in this field was badly needed. This one is comprehensive, is well selected, and is excellently edited and presented. It is made up on the whole of stimulating material and it belongs in all libraries in the psychoanalytic field.

**An Appraisal of Anthropology Today.** Sol Tax, Loren C. Siseley, Irving Rouse and Carl F. Voegelin, editors. 395 pages including index. Cloth. University of Chicago Press. Chicago. 1953. Price \$6.00.

Anthropology in its widest sense may stand closer to psychiatry than does any other strictly non-medical discipline. In this symposium of its present-day status, we find personalities well known in the psychiatric world and techniques widely employed in psychiatry and psychology. There are, for instance, six index references to the Rorschach; and there is a discussion of psychosomatic medicine from the anthropologic point of view, as well as other closely related matters. The present symposium is a survey, not only of importance to the anthropologists themselves, but of a great deal of interest and some application, to the scientist in the related disciplines dealing with man, his physical and social organization and his personality.

**The Epidemiology of Health.** Iago Galdston, M. D., editor. ix and 197 pages. Cloth. Health Education Council. New York. 1953. Price \$4.00.

The treatment of health as a positive factor, rather than just the absence of disease, is a praiseworthy idea. But for the most part, the authors of the papers in this book seem to be at a loss for words when formulating this concept. The result is an overabundance of generalization—giving the feeling to the reader that the authors are groping toward ideas rather than expressing them.



**The Madeleine Smith Affair.** By PETER HUNT. 205 pages. Cloth. British Book Centre. New York. 1950. Price \$2.50.

This is a new version of the much-written-up trial and acquittal of Madeleine Smith for the arsenic poisoning of her lover. The author has had access to much unpublished material which, as he states, throws little light on her guilt or innocence but considerable on her character.

There is an introduction by the famous writer on criminology, William Roughead, in which he indicates belief in the lady's guilt. After Madeleine's acquittal, in 1857, she left Scotland; was married respectably to an artist who attained prominence; had children; and eventually appears to have come to the United States where, says Hunt: "She died on April 12, 1928 and was buried as Lena Wardle Sheehy in Mount Hope Cemetery, New York. She left £13 and an Insurance Policy worth \$30." The interest of this case to the criminologist and psychiatrist is, of course, obvious.

**Adrenal Cortex.** Transactions of the Fourth Conference. Elaine P. Ralli, M. D., editor. 165 pages. Cloth. Josiah Macy Jr. Foundation. New York. 1953. Price \$3.50.

These papers are of too technical a nature to be of value to persons not members of the medical profession. As always, the participants are leaders in their fields, and they bring a wide variety of viewpoints to the conference. The complexity of the interplay of the endocrine glands in the human body is only beginning to be understood, with the far-reaching effects they can have on the physical and mental make-up of the individual. While none of the articles discussed here deals directly with the hormones' effects on personality, studies on such subjects as "Mechanisms Through Which Adrenal Cortex Can Produce Qualitatively Different Effects" can conceivably have important psychiatric implications in the future.

**Society and the Homosexual.** By GORDON WESTWOOD. 184 pages. Cloth. Dutton. New York. 1953. Price \$3.00.

A popular treatise on homosexuality is written by a layman for British home consumption; why an American publisher should print it is unclear. The usual plea for understanding is submitted; the exaggerated Kinsey figures are taken as Bible; the author assumes that the English figures are even higher. The author is not informed about the newer psychoanalytic literature, stressing the homosexual's oral-masochistic regression. The author acknowledges, however, that homosexuality is "severe mental sickness" (p. 68), and recommends psychiatry. The book has an introduction by the British psychoanalyst, Edward Glover, which is regrettable in its superficiality. It is partly flippant, partly outdated.



**Portrait of Andre Gide.** By JUSTIN O'BRIEN. xii, 390 and xiv pages with index. Cloth. Knopf. New York. 1953. Price \$6.00.

Here is a literary study rather than a biography, but the author recognizes that with André Gide, far more so than with many other writers, his life, his background, and his writings are interrelated.

A major segment of Gide's work consists of the reworking of classical myths, and this book treats the part each of these myths plays in his thought. While there is an attempt to explain Gide's work in relation to his own emotional problems, there is no true exploration of the dynamics involved. Using the thematic rather than the chronological approach to the study of any writer is bound to create some confusion, but in this book it is kept to a minimum. The author presupposes considerable knowledge of Gide in his reader, and this book will be found of chief value to students of literature who wish to find a comprehensive picture of the man and his work. Despite the fact that the character analysis is on a surface level, it is valuable in its own right.

**Pattern for Successful Living.** By FRED PIERCE CORSON. 148 pages. Cloth. Winston. Philadelphia. 1953. Price \$2.50.

This is a brief inspirational volume replete with Biblical references and contemporary anecdotal exhortations. Spiritual problems of living are loosely categorized under 26 chapters and their solutions confidently found in the application of faith. Malfunction is attributed to the conscious individual, and help is seen to come from a self-willed application of Christian principles. Freud, Jung, and Adler are referred to for having "validated for current use the teachings of the New Testament." This book is easy reading, and the faithful will feel comfortably at home with it. It is not a book that will convince the patient who is struggling with religious problems.

**You Shall Know Them.** By VERCORS. 249 pages. Cloth. Little, Brown. Boston. 1953. Price \$3.50.

A French satire on racial discrimination is written here by Jean Bruller, who previously specialized in satirical drawings, and now (under the pseudonym of Vercors) has turned writer. The plot is far-fetched: A new type of humanoid ape is discovered; to prove it is human, a journalist allows artificial insemination of a female of the new species, murders "his" British baby, and requests trial for murder. The inability to define "man," gives the author the chance to ridicule all learned institutions, including the British courts. As typical in lengthy satires, the topic is too thin for a whole book.



## CONTRIBUTORS TO THIS ISSUE

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LAWSON G. LOWREY, M. D. Dr. Lowrey is a New York City psychiatrist, teacher, editor and writer; he has been in private practice since 1933. He was born in Missouri in 1890. A graduate of the University of Missouri in 1909, Dr. Lowrey taught anatomy there while working for his master's degree and later was professor of anatomy at the University of Utah and assistant professor of anatomy at the University of Missouri before going to Harvard Medical School where he was a teaching fellow in histology and embryology from 1912 to 1914. He received his medical degree from Harvard in 1915, was a fellow and was instructor there in neuropathology until 1920. He was an instructor in psychiatry from 1917 to 1920 and instructor in psychology in 1919 and 1920. He became assistant and associate professor of psychiatry at Iowa in 1920. Dr. Lowrey served as pathologist at Danvers (Mass.) State Hospital even before receiving his medical degree. He was on the staff of Boston Psychopathic Hospital as first assistant physician and chief medical officer from 1917 to 1920. Before moving to New York City, where he became director of the Institute for Child Guidance in 1927, he had served with child guidance clinics in Iowa, Minnesota, Ohio and Texas where he directed demonstration clinics for the National Committee for Mental Hygiene. He is now assistant clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University, and is an associate in psychiatry at the Vanderbilt Clinic.

Dr. Lowrey was editor of the *American Journal of Orthopsychiatry* from 1930 to 1948. He is now on the editorial boards of the *American Journal of Psychiatry* and of *Pastoral Psychology*. He is author or editor of a number of books on psychiatry and mental hygiene and of about 250 scientific articles, principally on psychiatric subjects.

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LUDWIG EIDELBERG, M. D. Dr. Eidelberg is a psychoanalyst in New York City and is the author of numerous scientific books and papers. Born in Poland in 1898, he received his medical degree from the University of Vienna in 1925. He is clinical associate professor at the State University of New York and is on the faculty of the New York Psychoanalytic Institute. He has been a member of the International Psychoanalytic Society since 1929. His books include *Take Off Your Mask* and *Studies in Psychoanalysis*. He has previously contributed to this QUARTERLY.

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NOLAN D. C. LEWIS, M. D. Dr. Lewis' paper in this issue of THE PSYCHIATRIC QUARTERLY is, in a sense, a final report from his years as director of the New York State Psychiatric Institute, a position he held since



1936. He retired on September 1, 1953 to become director of research in neurology and psychiatry of New Jersey hospitals and agencies, a position in which he will devote his full time to research and research planning.

Dr. Lewis was born in Coudersport, Pa., in 1889. A graduate in medicine of the University of Maryland, he served in Maryland general and mental institutions as pathologist, neuropathologist and psychiatrist before going to St. Elizabeths Hospital, Washington, D. C., where he served from 1919 to 1935 as pathologist, director of clinical laboratories and finally as director of laboratories. He came to New York City in 1936 as an associate director of the Neurological Institute and was named director of the Psychiatric Institute later that same year.

Dr. Lewis is managing editor of the *Journal of Nervous and Mental Disease*, the *Psychoanalytic Review* and the *Journal of Child Behavior*, and is editor of the section on psychiatry of the Yearbook series. He will continue with his scientific editorial work and with scientific writing. He is the author of a large number of scientific articles as well as a number of scientific books.

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EMANUEL F. HAMMER, Ph.D. Dr. Hammer is a New York City clinical psychologist who is at present senior research scientist in psychology on the Research Project of the New York State Psychiatric Institute. A graduate in arts from Syracuse University, his doctorate in clinical psychology is from New York University. He has served in educational, hospital and prison clinics, and came to the Psychiatric Institute from the position of senior psychologist and director of intern training at Lynchburg (Va.) State Colony. Dr. Hammer conducts the annual workshops in projective drawings (with emphasis on the H-T-P) at the Psychiatric Institute, and is a research and psychological consultant in the New York City public schools. He is author or co-author of numerous articles in the fields of social psychology, personality, child psychology, projective techniques and experimental psychopathology, and has contributed previously to this QUARTERLY.

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DÉSIRÉ ANNAU, M. D. Dr. Annau received his M. D. degree from the University of Budapest in 1923. Even as a medical student, he was interested in psychiatry and served a two-year externship in a state hospital in Budapest. After his graduation, he worked on the Psychiatric and Neurological Clinics in Zurich, at Burghölzli, in Paris, at the Salpêtrière, and in Vienna until 1928, when he began private practice in Novisad, Jugoslavia. In 1935, he became head physician of the Neuro-Psychiatric Sanatorium Bethania of the American Methodist Mission; and in 1941 chief physician of the mental department of the General Hospital in Novisad. In 1944, Dr. Annau was taken to Germany with a hospital. After the liber-



ation, he became chief physician of the neuropsychiatric department of a hospital for displaced persons in Germany. In September 1949, he came to the United States and has been employed at Marey (N. Y.) State Hospital since that time. He is author of several neuropsychiatric papers.

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**FRANCIS C. BAUER, M. D.** Dr. Bauer received his B. S. degree from St. John's University, Brooklyn, and did postgraduate work at New York University. Following two years of bacteriology at Mt. Sinai Hospital in New York, he entered Georgetown Medical School, Washington, D. C. He became interested in psychiatry during undergraduate affiliation at St. Elizabeths Hospital and the neuropsychiatric service at Bethesda Naval Hospital. He received his medical degree from Georgetown in 1949 and after an internship of one year joined the staff at Pilgrim (N. Y.) State Hospital, where he is now a senior psychiatrist.

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**WERNER M. COHN, M. D.** Dr. Cohn received his medical degree from the University of Berlin in 1947. After serving two years internship in this country, he joined the staff of Hudson River State Hospital and is at present a senior psychiatrist at that institution.

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**ALBERT E. SCHEFLEN, M. D.** Dr. Scheflen is a Philadelphia psychiatrist, at present associated with Dr. Kenneth E. Appel at the Institute of Pennsylvania Hospital, Philadelphia. Born in Camden, N. J., in 1920, he is a graduate of Dickinson College and a graduate in medicine of the University of Pennsylvania in 1945. After interning in the U. S. Naval Hospital in Philadelphia, he served as a naval medical officer until 1949, both at sea and on neuropsychiatric services. He was at Worcester (Mass.) State Hospital and engaged in research at Tufts Medical College in 1950 and 1951, later going to Delaware State Hospital for a year. He is a student in the Philadelphia Psychoanalytic Institute and instructor in psychiatry at the medical school of the University of Pennsylvania, and is the author of a number of psychiatric papers, most of them dealing with insulin and geriatric psychiatry.

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**JOSEPH BARNETT, M. D.** Dr. Barnett was born in New York City in 1926. He attended Queens College of the City of New York and later the Chicago Medical School, graduating in 1948 with a B. M. degree. He received his M. D. in 1949 after a year of rotating internship at the Ottawa Civic Hospital in Canada. He served as resident psychiatrist at Rochester (N. Y.) State Hospital from 1949 to 1951, including three months as assistant resident in psychiatry at Strong Memorial Hospital of the University of Rochester Medical School. From 1951 to 1952, he served as resident



and senior psychiatrist at Syracuse (N. Y.) Psychopathic Hospital with part-time assignment to the Onondaga County Child Guidance Center, and as assistant resident in neurosurgery at Memorial Hospital in Syracuse.

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ARTHUR LEFFORD, M. A. Mr. Lefford received his training in clinical psychology at Ohio State University with further training at New York University. During World War II he served overseas in the medical department of the army. Returning from service, he taught psychology at New York University, and was assistant technical director of experimental psychology of a project of the Office of Naval Research. In 1950, he went to Syracuse (N. Y.) Psychopathic Hospital as staff psychologist, and received a Millbank Foundation grant as a research fellow for the New York State Mental Health Commission. He is at present a candidate for the Ph.D. degree, and is engaged in basic research in the relationship of perception to personality as indicated by the Szondi experimental method.

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DONALD PUSHMAN, M. D. Dr. Pushman was born in Ottawa, Canada, in 1925. He is a graduate of the University of Toronto receiving his M. D. degree in 1950. He served a rotating internship at St. Paul's Hospital, Vancouver, British Columbia until June 1951. At the present time he is a resident psychiatrist at Syracuse (N. Y.) Psychopathic Hospital.

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LAURETTA BENDER, M. D. Dr. Bender has been senior psychiatrist at Bellevue (New York City) Hospital since 1930 and has been in charge of the children's service there since 1934. She is professor of clinical psychiatry at the New York University College of Medicine where she has been on the faculty since 1930.

Dr. Bender is the author of a large number of papers in the fields of psychology, neurology and psychiatry, particularly with reference to children. She is a graduate of the State University of Iowa, from which she received her medical degree in 1926. She was married to Dr. Paul Schilder in 1936; he died in 1940.



## NEWS AND COMMENT

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### HUTCHINGS MEMORIAL AWARD STILL OUTSTANDING

The \$100 special memorial award to be made by the Richard H. Hutchings Memorial Committee for an outstanding contribution to psychiatry from a public mental institution is still pending. The award is presented by an anonymous donor through the late D. Charles Burlingame, M. D. psychiatrist-in-chief of the Institute of Living, Hartford, Conn., who was a member of the Hutchings Memorial Committee.

The award, offered some four years ago, is to be awarded by the memorial committee at a time within its discretion. The committee has felt up to this time that there have been insufficient nominations and more would be welcomed now. The award is without restriction as to type of professional achievement; scientific articles, reports or nominations for the award should be submitted to the chairman of the memorial committee, Dr. Harry A. Steckel, Suite 1804, State Tower Building, Syracuse 2, N. Y.

The award is open not only to members of the New York State hospital system but also to those of other states and to workers in federal and local institutions.

The fifth annual Hutchings Memorial Lecture, conducted under the auspices of the memorial committee, the Onondaga County Medical Society, the Syracuse Academy of Medicine, and the College of Medicine, Syracuse University, was given on October 5, 1953 by Bernard C. Glueck, Jr., M. D. Dr. Glueck, who is director of the Sex Offender Research Project of the New York State Department of Mental Hygiene and is supervising psychiatrist at Sing Sing Prison, spoke on "Psychodynamic Patterns in the Sex Offender." His lecture will be published in this *QUARTERLY*.

Dr. Hutchings, in whose memory the lectures are being held, died in October 1947 after an outstanding career in psychiatry. He had been superintendent of both Utica and St. Lawrence (N. Y.) State Hospitals, had been president of the American Psychiatric Association, and was editor of *THE PSYCHIATRIC QUARTERLY* at the time of his death. He was professor of clinical psychiatry for many years at the Syracuse College of Medicine where the annual lectures are held, and teaching was one of his life-long interests. His best-known publication is in the teaching field, *Psychiatric Work Book*, a manual for students and practitioners of medicine, nursing, psychiatric social work and allied disciplines.

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### LEWIS LEAVES INSTITUTE AFTER 17 YEARS

Nolan D. C. Lewis, M. D., director since 1936 of the New York State Psychiatric Institute, retired on September 1, 1953, to become director of re-



search in neurology and psychiatry of New Jersey hospitals and agencies. He plans to devote his entire time to research and research planning and will continue writing and editing. Brief biographical notes on Dr. Lewis' career appear under the heading "Contributors to This Issue" on pages 718 and 719 of this *QUARTERLY*.

In other important changes among the personnel of the New York State Department of Mental Hygiene, Raymond G. Wearne, M. D., director of Wassaic State School since 1937, retired on July 1; and Richard V. Foster, M. D., director of Gowanda State Homeopathic Hospital since 1951, was appointed to a new position as an assistant commissioner of the department on April 15.

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#### NEW INTERNATIONAL PSYCHIATRIC JOURNAL IS ANNOUNCED

A new quarterly, *Acta Psychotherapeutica, Psychosomatica, Orthopaedagogica*, has been announced for publication in Leyden, the Netherlands, with the first issue to appear in January 1954. It will publish original articles in French, German and English; and American editors are Franz Alexander and Flanders Dunbar. Chief editors are E. A. D. Carp and B. Stokvis, both of Leyden.

A new annual in the mental hygiene field will appear in January with the first issue of the *Annual of Pastoral Psychology*. It will be published by the monthly journal, *Pastoral Psychology*, and will be, says the publishers' announcement, "devoted entirely to a listing of significant reference and resource material for the minister, clinical psychologist, psychiatrist, and all other workers in the field of human behavior."

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#### INTERNATIONAL CONGRESS TO MEET IN ZURICH

An international congress for psychotherapy has been announced for Zurich from July 21 to July 24, 1954, under the auspices of the Swiss Medical Association of Psychotherapists. The subject will be "Transference in Psychotherapy"; and attendance is open to psychiatrists and psychotherapists who are members of national professional associations or recognized societies, and to others properly recommended.

The International Association for Child Psychiatry will hold a two-day international institute in Toronto on "The Emotional Problems of Children under Six," August 12 to 14, 1954 in connection with the Fifth International Congress on Mental Health. Professional workers of all disciplines concerned may attend, and the association invites clinical case studies for presentation and discussion.

The First International Congress on Group Psychotherapy is also scheduled for Toronto from August 12 to 14. The membership of the sponsoring committees, it is announced, includes representatives "of all varieties of



group psychotherapy, without discrimination." Representatives from 17 nations are sponsoring the meeting.

The First Latin-American Congress on Mental Hygiene will be one of 10 scientific congresses to be conducted in São Paulo, Brazil, during July 1954, in observation of the fourth centenary of the city of São Paulo. It will be sponsored by the São Paulo Medical Association.

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### IS YOUR HOUSE HAUNTED?

A mental health booklet, *Haunted House*, dealing in simple language with the problems of fear, worry and anxiety, has been issued by the New York State Department of Mental Hygiene and is available for distribution by agencies and organizations interested in the promotion of mental health. Illustrated by Joe Musial, and with the brief text by Margaret Farrar, the booklet is printed in two colors. The cover is a replica of the Haunted House exhibit which the Department of Mental Hygiene presented at the New York State Fair in Syracuse in September 1953. Commissioner of Mental Hygiene Newton Bigelow, M. D., was psychiatric adviser for the publication.

Copies are free to New York State agencies and organizations interested in its distribution, and single copies are free to anybody anywhere. Requests should be addressed to the New York State Department of Mental Hygiene, Albany, N. Y.

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### NEW POSITIONS ANNOUNCED BY DEPARTMENT

New research and administrative positions were announced by the New York State Department of Mental Hygiene during the spring and summer of 1953.

Charles I. McAllister of West Hempstead, supervisor of the New York City public school program for children with retarded mental development, was named on September 16 as supervisor of education for the Department of Mental Hygiene. The position is a new one and Mr. McAllister's duties will cover development of the academic program for children in state schools for mental defectives.

In a special research appointment, Dr. Bjorn Vestergaard, Danish psychiatrist, was named to the staff of the research project headed by Dr. Nathan S. Kline at Rockland State Hospital. He will serve with the title of research scientist, as an assistant to Dr. Kline.

In another departmental educational development, some 200 first-year nursing students of the Department of Mental Hygiene enrolled in the freshman classes of New York State colleges and universities in September. The affiliation of department schools with institutions of university grade began three years ago. It was expanded this year to include eight such institutions.



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